

# Welcome

Thank you for selecting Drs. Williams and Williams dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink, and bring it with you on your next visit. If you have any questions or need assistance we will be happy to help.

## Patient Information (CONFIDENTIAL)

Date \_\_\_\_\_

Name \_\_\_\_\_ Birth Date \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Email Address \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Check Appropriate Box  Minor  Single  Married  Divorced  Widowed  Separated

If student, Name of School/College \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_  Full Time  Part Time

Patient or Parents Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Spouse or Parent's Name \_\_\_\_\_ Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

How did you hear about our office  Current Patient? Who can we thank? Name: \_\_\_\_\_  Yellowpages

Internet Web Search  Citysearch  Doctor  School Presentation  Other (please specify) \_\_\_\_\_

Person to contact in case of emergency \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

## Legally Responsible Party

Name of person responsible for this account \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Address \_\_\_\_\_ Home Phone \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Is this person currently a patient in our office?  Yes  No

**Insurance Information** We ask you to understand that regardless of insurance coverage, payment is expected at the time of service. Insurance contracts are between the patient and your insurance company. Your insurance company is responsible to you, and you are responsible to Drs. Williams and Williams. **We will be glad to assist you in filing your insurance.** Our office files electronically, which expedites your reimbursement.

Name of Insurance Company \_\_\_\_\_ Address \_\_\_\_\_ C/S/Z \_\_\_\_\_

Employer \_\_\_\_\_ Subscriber ID \_\_\_\_\_ Group# \_\_\_\_\_

Policy Holder \_\_\_\_\_ DOB \_\_\_\_\_ SS# \_\_\_\_\_

Do you have any additional insurance?  Yes  No IF YES, COMPLETE THE FOLLOWING:

Name of Insured \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Birth Date \_\_\_\_\_ Social Security # \_\_\_\_\_

Name of Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group# \_\_\_\_\_ Policy/ID# \_\_\_\_\_

Ins. Co. Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Date \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_ Signature \_\_\_\_\_

Date \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_ Signature \_\_\_\_\_

Date \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_ Signature \_\_\_\_\_

# Patent Medical History

Physician \_\_\_\_\_ Office Phone \_\_\_\_\_ Date of Last Exam \_\_\_\_\_

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| <p>1) Are you under medical treatment now? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2) Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? <input type="checkbox"/> Yes <input type="checkbox"/> No<br/>If yes, please explain: _____</p> <p>3) Are you taking any medication(s) including non-prescription medicine? <input type="checkbox"/> Yes <input type="checkbox"/> No<br/>If yes, what medication(s) are you taking? _____</p> <p>4) Have you ever taken Phen-Fen Or Redux? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>5) Do you use tobacco? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>6) Do you use controlled substances? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>7) Are you wearing contact lenses? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>8) Do you have a hearing impairment? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>9) Do you have or have you had any of the following?</p> | <p>10) Are you allergic to or have you had any reactions to:</p> <p>Local Anesthetics (e.g. novocaine)..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Penicillin or any other Antibiotics..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Sulfa Drugs..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Barbituates..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Sedatives..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Iodine..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Aspirin..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Any Metals (e.g. nickel, mercury etc)..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Latex Rubber..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Other (Please list) _____</p> <p>11) Women Only:</p> <p>a) Are you pregnant or think you may be pregnant?..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>c) Are you taking oral contraceptives?..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>b) Are you nursing?..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> |
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| <p>High Blood Pressure..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Heart Attack..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Rheumatic Fever..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Swollen Ankles..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Fainting/Seizures..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Asthma..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Low Blood Pressure..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Epilepsy/Convulsions..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Leukemia..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Diabetes..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Kidney Diseases..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>AIDS or HIV Infection..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Thyroid Problem..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> | <p>Heart Disease..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Cardiac Pacemaker..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Heart Murmur..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Angina..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Frequently Tired..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Anemia..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Emphysema..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Cancer..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Arthritis..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Joint Replacement or Implant..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Hepatitis/Jaundice..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Sexually Transmitted Disease..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Stomach Troubles/Ulcers..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> | <p>Chest Pains..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Easily Winded..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Stroke..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Hay Fever/Allergies..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Tuberculosis..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Radiation Therapy..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Glaucoma..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Recent Weight Loss..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Liver Disease..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Heart Trouble..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Respiratory Problems..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Mitral Valve Prolapse..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Other..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> |
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# Patent Dental History

Name of previous Dentist and Location \_\_\_\_\_ Date of Last Exam \_\_\_\_\_

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| <p>1) Do your gums bleed while brushing and flossing? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2) Are your teeth sensitive to hot or cold liquids or foods? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>3) Are your teeth sensitive to sweet or sour liquids/foods? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>4) Do you feel pain to any of your teeth? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>5) Do you have any sores or lumps in or near your mouth? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>6) Have you had any head, neck or jaw injuries? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>7) Have you ever experienced any of the following problems in your jaw?</p> <p>Clicking..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Pain (joint, ear, side of face)..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Difficulty in opening or closing..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Difficulty in Chewing..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> | <p>8) Do you have frequent headaches? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>9) Do you clench or grind your teeth? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>10) Do you bit your lips or cheeks frequently? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>11) Have you ever had any difficult extractions in the past? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>12) Have you ever had any prolonged bleeding following extractions? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>13) Have you had any orthodontic treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>14) Do you wear dentures or partials? <input type="checkbox"/> Yes <input type="checkbox"/> No<br/>If yes, date of placement? _____</p> <p>15) Have you ever received oral hygiene instructions regarding the care of your teeth/gums? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>16) Do you like your smile? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> |
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# Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on behalf or my dependants.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of patient (or parent if minor)