Dr. Robert L. Williamson, III
Chart #:

Patient Information

Patient Name: ______________________________ Date: ________
Last, First MI (Preferred Name)

Gender: ________ Family Status: ☐ Single ☐ Married ☐ Child ☐ Other ________________

Social Security #: ____________ Birth Date: ____________ Driver's License ____________

Phone (Home): ____________ (Work): ____________ Ext: ________ Best time to call: ____________

Address: ____

Employer Name: ______________________ Occupation: ______________________

Spouse's Name: ______________________ Email: ______________________

Referral Information

Whom may we thank for referring you to our practice? ☐ Another patient, friend ☐ Another patient, relative
☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other ____________

Name of person or office referring you to our practice: Dr. Freeman

Two People to contact in case of emergency:

Name ______________________ Telephone # ____________

Address ____

Name ______________________ Telephone # ____________

Address ____

Dental Insurance Information

Primary

Name of Insured: ______________________ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: ____________ ID #: ____________ Group #: ____________

Insured's Address: ____
Street City State Zip Code

Insured's Employer Name: ____

Address: ____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other ____________

Insurance Plan Name and Address: ____

Secondary

Name of Insured: ______________________ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: ____________ ID #: ____________ Group #: ____________

Insured's Address: ____
Street City State Zip Code

Insured's Employer Name: ____

Address: ____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other ____________

Insurance Plan Name and Address: ____

Responsible Party Information

Person Responsible for Account: Name: ____
☐ Patient ☐ Father ☐ Mother ☐ Guardian

Method of Payment: ( ) Check ( ) Visa/MasterCard ( ) Cash ( ) CareCredit

Where appropriate and necessary, credit bureau reports will be obtained.

Authorization: I hereby authorize payment directly to Dr. Robert L. Williamson III, D.D.S., P.A., of the group insurance benefits otherwise payable to me. I understand that Dr. Robert L. Williamson III, D.D.S., P.A., is not in network with any insurance company. I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the medical history are correct to the best of my knowledge.

•Signature of Responsible Party Date

Health Information

Date of Last Dental Visit: ___________________ Reason for this visit: ___________________

Dental History: Would you describe your present dental health as good? ☐ Yes ☐ No

If no, please explain: ___________________

• Do you think you have active decay or gum disease? ☐ Yes ☐ No

Please explain: ___________________

• Do your gums ever bleed? ☐ Yes ☐ No

If yes, when? ___________________

• How often do you brush?___________________ Floss? ___________________

•Do you feel nervous about dental treatment? ☐ Yes ☐ No

• Have you ever had a bad experience in a dental office? ☐ Yes ☐ No

Describe ___________________

• Have you ever had braces? ☐ Yes ☐ No •Is your water fluoridated? ☐ Yes ☐ No

• Have you had any prior dental trauma? ☐ Yes ☐ No

If yes, please explain: ___________________

•Do you like your smile? ☐ Yes ☐ No

If no, please explain: ___________________

• Name of previous dentist___________________

Medical History: Medical Doctor's Name & Phone # ___________________

• Are you under a physician's care now? ☐ Yes ☐ No

If yes, please explain: ___________________

•Have you been hospitalized in the past two years? ☐ Yes ☐ No

If yes, please explain: ___________________

• Are you taking any medications, pills, drugs, or herbal supplements? ☐ Yes ☐ No

If yes, please describe what, why, and dosage: ___________________

____

____

• Are you allergic to penicillin, codeine, or any other medication? ☐ Yes ☐ No

If yes, list medication & describe reaction: ___________________

• *(Women)* Pregnant or nursing? ☐ Yes ☐ No • Do you take premedication for dental treatment? ☐ Yes ☐ No

• Do your smoke? ☐ Yes ☐ No • Do you use alcohol? ☐ Yes ☐ No

• Are your immunizations up to date? ☐ Yes ☐ No **• Are you allergic to latex? ☐ Yes ☐ No**

Have you ever had any of the following? Please check those that apply:

☐ Heart Trouble	☐ Chest Pain	☐ Asthma	☐ Xray or Cobalt Tmt.	☐ Hemophilia/Bleeding
☐ High Blood Pressure	☐ Shortness of Breath	☐ Sinus Trouble	☐ Arthritis/Gout	☐ HIV Positive
☐ Heart Murmur	☐ Faintness or Dizziness	☐ Lung Disease	☐ Rheumatism	☐ Aids
☐ Mitral Valve Prolapse	☐ Stroke	☐ Tuberculosis	☐ Alcohol Addiction	☐ Venereal Disease
☐ Rheumatic Fever	☐ Diabetes	☐ Liver Disease	☐ Cortisone Medicine	☐ Cold sores/fever blisters
☐ Congenital Heart Lesion	☐ Excessive Thirst	☐ Hepatitis A (Infect)	☐ Glaucoma	☐ Herpes
☐ Artificial Heart Valve	☐ Artificial Joint/Hip	☐ Hepatitis B (Serum)	☐ Epilepsy or seizures	☐ Eating Disorders
☐ Heart Pacemaker	☐ Kidney Trouble	☐ Hepatitis C (Serum)	☐ Hypoglycemia	☐ Psychiatric Problems
☐ Heart Surgery	☐ Ulcers	☐ Yellow Jaundice	☐ Chemotherapy	☐ Frequent Headaches
☐ Blood Disease	☐ Allergies	☐ Cancer	☐ Drug Addiction	☐ ADD/DHD
☐ Anemia	☐ Scarlet Fever	☐ Thyroid Problem	☐ Pain in Jaw Joint	

Please list any other serious illness if not indicated above___________________

• I understand that if any change occurs in my health, I am to report it to the dental office as soon as possible; I have read, and understand each question and have answered all of them truthfully and to the best of my ability; I have discussed my health history with the doctor.

___________________ ___________________

Signature of patient, parent or guardian Date

___________________ ___________________

Signature of Doctor Date

Medical Updates:

I have read my Medical History dated ________ and confirm that it adequately states past and present conditions.

Date	Exceptions	Patient Signature	Reviewed By
________	________	________	________
________	________	________	________
________	________	________	________
________	________	________	________