

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 _____

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: _____

Two People to contact in case of emergency:

Name _____ Telephone # _____

Address _____

Name _____ Telephone # _____

Address _____

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 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 you 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:

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