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 |
|---|---|---|---|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |