ClearwaterSmiles

WELCOME TO OUR PRACTICE!

Name _____ Date of Birth _____

Title: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Dr. Sex: ☐ Male ☐ Female

Address _____ E-mail _____

City _____ State _____ Zip Code _____

Cell Phone _____ Home Phone _____ Work Phone _____

Social Security Number _____ Driver's License Number _____

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Employer _____ Occupation _____

Employer Address _____ Phone _____

City _____ State _____ Zip Code _____

Person Responsible For Account (If different from Patient)

Name _____ Date of Birth _____

Address _____ E-mail _____

City _____ State _____ Zip Code _____

Cell Phone _____ Home Phone _____ Work Phone _____

Social Security Number _____ Driver's License Number _____

Spouse's Name: _____ Social Security Number _____

Spouse's Employer _____ Occupation _____

Cell Phone _____ Work Phone _____

Emergency Contact Person _____ Phone _____

Do you have a dental plan or dental insurance? ☐ Yes ☐ No If so, please bring Insurance Card

How did you hear about our office? _____

Who may we thank for referring you? _____

I understand that I am responsible for all charges incurred whether or not I have dental insurance coverage. I understand that treatment estimates quoted are subject to my insurance program allowances and limitations and may or may not reflect or guarantee the actual payment of my carrier(s). I authorize this office to release any and all information necessary to secure reimbursement from any insurance to which I have now or may have in the future. I authorize and direct payment to Allen L. Williams, DMD for the dental services rendered. I agree and understand that I may be charged 1.5% interest per month on any unpaid balance and further understand I am responsible for any cost incurred in collection or litigation of said balance should that become necessary.

_____ _____

Signature of Patient, Parent, Guardian or Patient Representative DATE

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MEDICAL HISTORY

Name _____ Date of Birth _____

Check (✓) if you have or have had any of the following:

AIDS	☐ Yes ☐ No	Dizziness	☐ Yes ☐ No	Lupus	☐ Yes ☐ No
Alzheimer's Disease	☐ Yes ☐ No	Drug Addiction	☐ Yes ☐ No	Mitral Valve Prolapse	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Emphysema	☐ Yes ☐ No	Organ Transplant	☐ Yes ☐ No
Angina (Chest Pain)	☐ Yes ☐ No	Endocarditis	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No
Arrythmia	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	Fibromyalgia	☐ Yes ☐ No	Parkinson's Disease	☐ Yes ☐ No
Artificial Heart Valve	☐ Yes ☐ No	Gastric Reflux	☐ Yes ☐ No	Psychiatric Condition	☐ Yes ☐ No
Artificial Joint	☐ Yes ☐ No	GERD	☐ Yes ☐ No	Radiation	☐ Yes ☐ No
Atrial Fibrillation	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Respiratory Disease	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Headaches	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Back Problems	☐ Yes ☐ No	Heart Attack	☐ Yes ☐ No	Shingles	☐ Yes ☐ No
Bleeding Problems	☐ Yes ☐ No	Heart Murmur	☐ Yes ☐ No	Shortness of Breath	☐ Yes ☐ No
Blood Disease	☐ Yes ☐ No	Heart Surgery	☐ Yes ☐ No	Sickle Cell Disease	☐ Yes ☐ No
Cancer_____	☐ Yes ☐ No	Hemophilia	☐ Yes ☐ No	Sjogren's Syndrome	☐ Yes ☐ No
Chemotherapy	☐ Yes ☐ No	Hepatitis Type _____	☐ Yes ☐ No	Snoring / Sleep Apnea	☐ Yes ☐ No
Chicken Pox	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Stroke or TIA	☐ Yes ☐ No
Congenital Heart Disease	☐ Yes ☐ No	HIV Positive	☐ Yes ☐ No	Swelling of Ankles	☐ Yes ☐ No
Contact Lenses	☐ Yes ☐ No	Irregular Heartbeat	☐ Yes ☐ No	Thyroid Condition	☐ Yes ☐ No
COPD	☐ Yes ☐ No	Jaundice	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Defibrillator	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Tumors	☐ Yes ☐ No
Dementia	☐ Yes ☐ No	Leukemia	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No
Diabetes Type_____	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Vertigo	☐ Yes ☐ No

Describe any disease, condition or problem you have that was not listed above _____

_____

Have you ever taken or been given bisphosphonate drugs (Fosamax, Aredia, Zometa, Reclast, etc.) for osteoporosis or cancer? ☐ YES ☐ NO If so, list drug(s) _____

Do you use tobacco in any form? ☐ YES ☐ NO If yes, how much?_____

Do you drink more than two alcoholic beverages per day? ☐ YES ☐ NO

Do you use recreational (street) drugs? ☐ YES ☐ NO

Women: Are you or could you be pregnant? ☐ YES ☐ NO If yes due date _____

Are you nursing? ☐ YES ☐ NO

Are you on Birth Control? ☐ YES ☐ NO

Are you allergic to or have you ever had a reaction to any of the following?

Aspirin	☐ YES ☐ NO	Hydrocodone	☐ YES ☐ NO	Nickel	☐ YES ☐ NO
Codeine	☐ YES ☐ NO	Jewelry	☐ YES ☐ NO	Penicillin.....	☐ YES ☐ NO
Clindamycin	☐ YES ☐ NO	Latex.....	☐ YES ☐ NO	Tetracycline.....	☐ YES ☐ NO
Epinephrine	☐ YES ☐ NO	Lidocaine	☐ YES ☐ NO	Valium.....	☐ YES ☐ NO
Erythromycin	☐ YES ☐ NO	Metals.....	☐ YES ☐ NO	Other _____	☐ YES ☐ NO

_____ _____

Signature of Patient, Parent, Guardian or Patient Representative DATE

_____ _____

Signature of Doctor DATE

UPDATED _____

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MEDICATIONS AND DENTAL HISTORY

Name _____ Date of Birth _____

Please list all medications (prescribed and over-the-counter), vitamins and supplements.
Include any herbal supplements/medications:

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Physician _____ Phone #(_____)-_____

Cardiologist _____ Phone #(_____)-_____

Pharmacy _____ Phone #(_____)-_____

DENTAL HISTORY

Check (✓) if you have or have had any of the following:

Antibiotic Premedication	☐ YES	☐ NO	Gum Disease (Pyorrhea)	☐ YES	☐ NO
Bad Breath	☐ YES	☐ NO	Orthodontics (Braces)	☐ YES	☐ NO
Bleeding Gums	☐ YES	☐ NO	Pain in Jaw Joint/Muscles	☐ YES	☐ NO
Canker Sores	☐ YES	☐ NO	Periodontal Treatment/Surgery	☐ YES	☐ NO
Clenching/Grinding	☐ YES	☐ NO	Sensitivity to Biting/Chewing	☐ YES	☐ NO
Clicking/Popping Jaw	☐ YES	☐ NO	Sensitivity to Cold	☐ YES	☐ NO
Cold Sores/Fever Blisters	☐ YES	☐ NO	Sensitivity to Hot	☐ YES	☐ NO
Deep Cleanings (Root Planing)	☐ YES	☐ NO	Sensitivity to Sweets	☐ YES	☐ NO
Difficulty Reclining	☐ YES	☐ NO	Severe Gag Reflex	☐ YES	☐ NO
Fear of Treatment	☐ YES	☐ NO	TMJ Problems	☐ YES	☐ NO

What is the main reason for your dental visit?

_____

_____

_____ _____

Signature of Patient, Parent, Guardian or Patient Representative DATE

_____ _____

Signature of Doctor DATE