MIKE WILLIAMSON
DDS | MS

PATIENT

DATE..... NAME..... NICKNAME..... ☐ MALE ☐ FEMALE

ADDRESS..... CITY..... STATE..... ZIP.....

HOME PHONE..... CELL PHONE..... EMAIL ADDRESS.....

OCCUPATION..... EMPLOYER..... WORK PHONE.....

AGE..... DATE OF BIRTH..... SS#..... MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED

SPOUSE'S NAME..... PARENT/GUARDIAN IF PATIENT IS A MINOR.....

ANY FAMILY MEMBERS THAT ARE PATIENTS HERE?..... WHOM MAY WE THANK FOR REFERRING YOU?.....

EMERGENCY CONTACT PERSON..... PHONE..... RELATIONSHIP.....

RESPONSIBLE PARTY

— IF DIFFERENT FROM PATIENT —

NAME..... RELATIONSHIP TO PATIENT: ☐ SPOUSE ☐ PARENT ☐ GUARDIAN

ADDRESS..... CITY..... STATE..... ZIP.....

HOME PHONE..... CELL PHONE..... EMAIL ADDRESS.....

EMPLOYER..... WORK PHONE..... SS#.....

DENTAL INSURANCE

INSURED'S NAME (POLICYHOLDER)..... DATE OF BIRTH.....

ID..... GROUP# ..... INSURANCE COMPANY.....

ADDRESS..... CITY..... STATE..... ZIP.....

EMPLOYER THAT PROVIDES INSURANCE..... INSURED'S RELATIONSHIP TO PATIENT: ☐ SELF ☐ SPOUSE ☐ PARENT ☐ OTHER

✱ IF YOU HAVE DUAL INSURANCE, PLEASE PROVIDE THE INFORMATION FOR YOUR SECONDARY CARRIER BELOW:

INSURED'S NAME (POLICYHOLDER)..... DATE OF BIRTH.....

ID..... GROUP# ..... INSURANCE COMPANY.....

ADDRESS..... CITY..... STATE..... ZIP.....

EMPLOYER THAT PROVIDES INSURANCE..... INSURED'S RELATIONSHIP TO PATIENT: ☐ SELF ☐ SPOUSE ☐ PARENT ☐ OTHER

HEALTH HISTORY

For your safety and to assist us in accurately diagnosing and treating you, please review this form completely and fill out areas which pertain to you.
All information is private and confidential.

✱ DENTAL HEALTH

YOUR DENTIST.....

CITY.....

HOW LONG..... DATE OF LAST VISIT.....

LAST CLEANING..... LAST X-RAYS.....

DO YOU WANT TO KEEP YOUR TEETH?

☐ YES, NO MATTER WHAT ☐ YES, IF IT'S NOT TOO MUCH TROUBLE
☐ I'M NOT SURE ☐ IT DOESN'T MATTER

CHECK ANY OF THE FOLLOWING YOU HAVE HAD, OR CURRENTLY HAVE:

☐ MOUTH DISCOMFORT
☐ PREVIOUS PERIODONTAL TREATMENT
☐ GRIND OR CLENCH YOUR TEETH
☐ ORTHODONTIC TREATMENT
☐ SENSITIVE TEETH (HOT, COLD, SWEETS)
☐ FEAR OF DENTAL TREATMENT
☐ BAD DENTAL EXPERIENCE
☐ IMMEDIATE RELATIVES WHO LOST ALL THEIR NATURAL TEETH
☐ COMPLICATIONS WITH, OR FOLLOWING, PREVIOUS DENTAL OR ORAL SURGICAL TREATMENT

OTHER.....

OVER > > >

✱ MEDICAL HEALTH

• HOW WOULD YOU DESCRIBE YOUR PRESENT HEALTH? ☐ EXCELLENT ☐ GOOD ☐ FAIR ☐ POOR

• LIST YOUR CURRENT PHYSICIAN(S):

..... TYPE ..... HOW LONG?.....

..... TYPE ..... HOW LONG?.....

• DATE OF LAST COMPLETE PHYSICAL EXAM..... PURPOSE.....

• FINDINGS ..... HEIGHT ..... WEIGHT.....

• ARE YOU AWARE OF ANY CHANGES IN YOUR GENERAL HEALTH IN THE LAST YEAR? NO YES .....

• HAVE YOU BEEN HOSPITALIZED FOR ILLNESS OR SURGERY IN THE PAST TWO YEARS? NO YES .....

• HAVE YOU BEEN UNDER A MEDICAL DOCTOR'S CARE DURING THE PAST TWO YEARS? NO YES .....

• HAVE YOU EVER HAD EXCESSIVE BLEEDING THAT REQUIRED SPECIAL TREATMENT? NO YES .....

• IS THERE ANY HISTORY OF DIABETES IN YOUR FAMILY NO YES .....

• ARE YOU REQUIRED TO RESTRICT YOUR WORK ACTIVITY IN ANY WAY? NO YES .....

• ARE YOU ON A SPECIAL OR RESTRICTED DIET OF ANY KIND? NO YES .....

• DO YOU SMOKE OR USE TOBACCO PRODUCTS (CHEW / DIP)? NO YES HOW MUCH?..... HOW LONG?.....

• LIST ALL MEDICATIONS YOU ARE NOW TAKING AND WHAT YOU'RE TAKING THEM FOR (INCLUDE ALL OVER THE COUNTER). FOR EXAMPLE: "LIPITOR, FOR HBP"

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• PLEASE CIRCLE ANY OF THE FOLLOWING MEDICATIONS YOU ARE ALLERGIC TO, OR ARE UNABLE TO TAKE:

PENICILLIN	DOXYCYCLINE	CARBOCAINE	HALCION	TYLENOL	ANESTHETICS	DEMEROL	VERSED
ERYTHROMYCIN	CLINDAMYCIN	XYLOCAINE	IBUPROFEN	ASPIRIN	CODEINE	VALIUM	NALBUPHINE

OTHER .....

• INDICATE WHICH OF THE FOLLOWING YOU HAVE HAD/CURRENTLY HAVE BY CIRCLING YES OR NO:

HEART TROUBLE.....	NO YES	ARTIFICIAL JOINT (KNEE, HIP).....	NO YES	CANCERS OR TUMORS.....	NO YES
HEART DISEASE OR ATTACK.....	NO YES	KIDNEY/BLADDER TROUBLE.....	NO YES	RADIATION TREATMENT.....	NO YES
ANGINA.....	NO YES	THYROID DISEASE.....	NO YES	CHEMOTHERAPY.....	NO YES
HIGH BLOOD PRESSURE.....	NO YES	EMPHYSEMA.....	NO YES	ARTHRITIS/RHEUMATISM.....	NO YES
LOW BLOOD PRESSURE.....	NO YES	PERSISTENT COUGH.....	NO YES	GLAUCOMA.....	NO YES
HEART MURMUR.....	NO YES	TUBERCULOSIS.....	NO YES	HEPATITIS.....	NO YES
RHEUMATIC FEVER.....	NO YES	ASTHMA.....	NO YES	LIVER DISEASE.....	NO YES
CONGENITAL HEART LESIONS.....	NO YES	SINUS TROUBLES.....	NO YES	JAUNDICE.....	NO YES
ARTIFICIAL HEART VALVE.....	NO YES	ALLERGIES OR HIVES.....	NO YES	A.I.D.S.	NO YES
SCARLET FEVER.....	NO YES	DIABETES.....	NO YES	BLOOD TRANSFUSION.....	NO YES
HEART PACEMAKER.....	NO YES	FREQUENT THIRST AND/OR URINATION.....	NO YES	DRUG OR ALCOHOL ADDICTION.....	NO YES
HEART SURGERY.....	NO YES	STROKE.....	NO YES	VENEREAL DISEASE.....	NO YES
SHORTNESS OF BREATH UPON MILD EXERTION.....	NO YES	EPILEPSY OR SEIZURES.....	NO YES	A NERVOUS PERSON.....	NO YES
REQUIRE MORE THAN TWO PILLOWS TO SLEEP.....	NO YES	FREQUENT HEADACHES.....	NO YES	ULCERS.....	NO YES
ANEMIA.....	NO YES	FAINTING OR DIZZY SPELLS.....	NO YES	PSYCHIATRIC CARE.....	NO YES
SICKLE CELL DISEASE.....	NO YES	UNINTENTIONAL WEIGHT GAIN/LOSS.....	NO YES		

• ARE YOU TAKING, OR HAVE YOU TAKEN, BISPHOSPHONATE MEDICATIONS (FOSAMAX, ZOMETA, DIDRONEL, RECLAST, BONIVA, ACTONEL, ETC.)? NO YES

• IF FEMALE, ARE YOU: ☐ PREGNANT? ☐ TAKING BIRTH CONTROL PILLS? ☐ THROUGH MENOPAUSE? ☐ TAKING HORMONE MEDICATION?

• DO YOU HAVE ANY MEDICAL CONDITION/DISEASES NOT LISTED ABOVE THAT WE SHOULD KNOW ABOUT? NO YES EXPLAIN .....

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▶ ***TO THE BEST OF MY KNOWLEDGE, ALL OF THE PRECEDING ANSWERS ARE TRUE AND CORRECT. IF I EVER HAVE ANY CHANGES IN MY HEALTH, OR IF MY MEDICINES CHANGE, I WILL INFORM DR. WILLIAMSON ON OR BEFORE MY NEXT APPOINTMENT.***

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PATIENT'S SIGNATURE DATE DOCTOR'S SIGNATURE DATE