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........

CONTINUED >>>

## ✱ 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"

- PLEASE SELECT 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 SELECTING 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 IF YES, PLEASE EXPLAIN BELOW:

▶ ***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.***

........ PATIENT'S SIGNATURE ........ DATE ........ DOCTOR'S SIGNATURE ........ DATE