

## ALL PATIENT INFORMATION WILL BE KEPT STRICTLY CONFIDENTIAL

Patient Name:				Date:	
_	Last		MI		
Male Female Please circle	Married Single Chil	d Other		Email Address:	
If Married Please wr	ite spouse name here: _				
Social Security #:		Date of Birth:		DL#	
Phone (Home):		Cell:	Work:		
Address:					
Street		Apt #:			
City		State		Zip Code	
Employer Name:			Empl	oyer Ph #:	
If you are carrying d	ental insurance please li	st insurance carrier her	re:		
			4.		
Whom may we thank	k for referring you to ou	Referral Information practice?	mation		
		HEALTH HIS	TORY		
Physician Name:	Pł	none:	Date	e last seen:	
Are you now under th	ne care of a physician?	Yes No			
•	en admitted to a hospita ny medications you are o		care in the	e past two years? Yes No	
Please list ar	ny food, drug or seasona	l allergies:			
Have you ev	rer been diagnosed or tre	eated for any of the foll	owing (Ci	rcle all that apply)	
Heart Disease	Psychiatric Treatment	Jaundice	Arthritis	Sinus Trouble	$\neg$
Heart Murmur	High Blood Pressure	Asthma	Anemia	Osteoporosis	$\neg$
Tuberculosis	Rheumatic/Scarlet Fever	Joint Replacement	Diabete		
Epilepsy	Immune System Disorders	Angina	Fainting	Thyroid Trouble	

- Do you smoke or chew tobacco? Yes No
- (Women Only) Are you pregnant? Yes No
- Have you taken any osteoporosis/bisphosphonate drugs in the past 10 years? (ie Fosamax, Actonel, Alendronate)
- Do you have any health problems that need further clarification or are not listed here?

Any other disease, condition, or problem not listed above? Yes No Explain:

D + C1 + 1 + 1	DENTAL HISTO	RY	
<ul> <li>Date of last dental v</li> </ul>	risit:	Reason for today's visit	
	dental chair do you prefer Listenin		ce
<ul> <li>Do you brush daily?</li> </ul>	? Yes No Do you floss daily? Yes N	4o	
<ul> <li>How much soda poj</li> </ul>	o or sports drinks do you consume e	every week?	
Have you ever had a	any complications following dental	treatment? Yes No If so what?	
Are you having pair	n or sensitivity at this time? Yes No	o Explain:	
Are vou nervous or	apprehensive about dental treatmen	 it? Yes No	
	ith the appearance or color of your t		
Have you recently with them:	whitened your teeth? Yes No		
Have you ever had a	an unusual reaction to dental anesth		
Have you ever had a	any of the following? (Circle any the	at apply)	
Bleeding/Sore Gums	Food Trapped Between Teet	h Periodontal/Gun	n Treatment
C	11		
Clinching/Grinding Teeth Lo	bose/Shifting Teeth Extraction	Complications	
Orthodontic Treatment (Brac	ees) TMD/Clicking Jaw	Sensitivity to Hot/Cold	Facial/Dental Tra
orthodontic Treatment (Brac	cs) Tivid/Cheknig Jaw	bensitivity to 1100 cold	Taciai, Dentai Tra
Health	Questionnaire Consen	t & Financial Policy	
	Questionium consen		
		1 10	
certify that I have read an	ed understand the above and that t	he information given on this for	rm is accurate. I
	d understand the above and that toof a truthful health history and the		
inderstand the importance information for treating me.	of a truthful health history and the I acknowledge that my questions,	hat Dr. Williams and his staff vif any, about inquiries set forth	will rely on this above have been
nderstand the importance information for treating me. inswered to my satisfaction.	of a truthful health history and the I acknowledge that my questions, I will not hold Dr. Williams or his	hat Dr. Williams and his staff variety if any, about inquiries set forth a staff responsible for any action to	will rely on this above have been they may or may
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Terms: Net 30 days. Interest at the rate of 1.5% per month (18% annum), will be charged on all past due balances. In the event the account is delinquent and satisfactory arrangements have not been made for payment, all legal fees, attorney fees, court costs, including charges and collection agency fees of up to 40% of the balance assigned, with our without suit.

assumption that our charges will be paid in full by any insurance company. Please allow 24 hours notice for

appointment cancellations, broken appointments without notification are subject to a \$40 fee.

Signature of Patient or Legal Guardian

Date



INFORMED CONSENT TO	PHOTOGRAPH
I,	, do hereby give consent for Dr. Tyler
(Patient/Legal Guardian)	
Williams to take and/or disp	lay photograph(s) of my smile, including my teeth, lips and
educational purposes in lectu	used for a record of my dental care, and may be used for ares, demonstrations to other patients, and professional ng. My personal information, name, and identity will be kept
·	Date:
Relation to Patient: (circle or	
Patient Legal Guardian	
Please provide an email addı	ress if you'd like us to email you a copy of your
photos:	