MEDICAL HISTORY

1. For medical reasons, are you required to take antibiotics prior to dental treatment? YES ❑ NO ❑
   This includes, but is not limited to, a history of prosthetic heart valve or joint replacement surgery.

2. Are you allergic to penicillin, local anesthetics, latex, pain killers or any other drugs? If so, which:_____

3. Have you had abnormal bleeding associated with previous extractions, surgery, or trauma? YES ❑ NO ❑

4. Do you have or have you had any of the following?

YES	NO		YES	NO		YES	NO	
❑	❑	Panic attacks	❑	❑	Abnormal bleeding	❑	❑	Kidney trouble
❑	❑	Congenital heart disease	❑	❑	Asthma, hay fever, sinus trouble	❑	❑	Tuberculosis, lung disease
❑	❑	Cardiovascular: heart attack, coronary insufficiency, high blood pressure, arteriosclerosis coronary by pass, prosthetic valve, stroke, mitral valve prolapse	❑	❑	Hives or skin rash	❑	❑	Fainting spells or epilepsy
			❑	❑	Diabetes	❑	❑	Temporomandibular joint problems
			❑	❑	Hepatitis, jaundice, or liver disease	❑	❑	Psychiatric treatment
			❑	❑	Stomach ulcers	❑	❑	Acquired Immune Deficiency Syndrome (AIDS)
			❑	❑	Cancer/radiation therapy	❑	❑	Joint prosthesis (artificial knee, hip, ect.)
❑	❑	Shortness of breath	❑	❑	Frequent infections, fatigue	❑	❑	Veneral disease/STD

5. Are you taking any medications? YES ❑ NO ❑ If so, name them _____
6. Has there been any change in your general health within the past year? YES ❑ NO ❑
7. Are you pregnant? YES ❑ NO ❑
8. Do you take birth control pills/patch YES ❑ NO ❑
9. Do you smoke? YES ❑ NO ❑
10. Are you now under the care of a physician? YES ❑ NO ❑ If yes, nature of treatment _____
11. Are you addicted to, or recovering from, drugs or alcohol? YES ❑ NO ❑

Physician's Name _____ Phone _____

INFORMED CONSENT

This is my consent to the periodontic procedures indicated and any other procedures deemed necessary or advisable as a corollary to the planned periodontic therapy performed by the periodontist, hygienist, and any assistant required. I agree to the use of local anesthesia, sedation, and/or analgesia depending upon the judgement of the periodontist. Complications of periodontal therapy, dental implant surgery, tooth extraction, and/or anesthesia may include swelling, discomfort, infection, bleeding, sinus involvement, and numbness or tingling of the lip, gum, or tongue, which rarely is protracted and even more rarely is permanent.

I understand that periodontal therapy is a procedure to retain a tooth or teeth which may otherwise require extraction. Other treatment choices include no treatment, waiting for more definitive symptoms to develop, or tooth extractions. tooth extractions. Risks involved might include, but are not limited to, pain, infection, swelling, loss of teeth, and infection to other areas.

I understand that medications for discomfort and sedation may cause drowsiness which can be increased by the use of alcohol or other drugs. I will avoid operating any vehicle or hazardous devices while taking such medications. I further understand that certain medications may cause hives intestinal problems, and addiction. If any of these problems occur, I am to call the doctor immediately. I understand that it is my responsibility to report any changes in my medical history.

RECALL REVIEW:

1. Patient's Signature _____ Date _____ 5. Patient's Signature _____ Date _____
2. Patient's Signature _____ Date _____ 6. Patient's Signature _____ Date _____
3. Patient's Signature _____ Date _____ 7. Patient's Signature _____ Date _____
4. Patient's Signature _____ Date _____ 8. Patient's Signature _____ Date _____

Please let us know if you have any questions.

I have reviewed and understand your office policies and informed consent, and have completed all of the information requested.

_____ _____
(SIGNATURE) (DATE)

(If you are a minor, please have parent or guardian sign above.)

WELCOME TO OUR OFFICE

Thank you for choosing us as your health care provider. We are committed to your treatment being successful.

PATIENT INFORMATION RECORD

NOTE: California law requires that you keep your creditors advised of your current name, address and employment.

❒ Male
❒ Female

Date of Birth _____

Driver's License # _____

NAME _____ Social Security # _____
First Middle Last

Home Address _____ Phone _____
Street City State Zip

Status (✔): ( ) Married ( ) Single ( ) Divorced ( ) Minor Cell Phone _____

Employed by _____ Work Phone _____
Parent's information if a minor

Work Address _____ Occupation _____
City

SPOUSE _____ Date of Birth _____ SSN# _____
First Middle Last

Employed by _____ Occupation _____

Work Address _____ Phone _____

Name of person to notify in an emergency? _____ Relationship _____

Address _____ Phone _____
Street City State Zip

Were you referred to our office? Yes ❒ Self referred ❒ If yes, by whom? _____

RESPONSIBLE PARTY FOR PAYMENT

Date of Birth _____

NAME _____ Social Security # _____
First Middle Last

Home address _____ Phone _____
Street City State Zip

Employed by _____ Occupation _____

Work address _____ Phone _____

INSURANCE INFORMATION

PRIMARY DENTAL INS. CO _____ SECONDARY DENTAL INS. CO _____

ADDRESS _____ ADDRESS _____

NAME OF EMPLOYER _____ NAME OF EMPLOYER _____

GROUP# _____ SS# _____ DOB _____ GROUP# _____ SS# _____ DOB _____

The following is a statement of our Financial Policy which we require that you read, agree to, and sign prior to any treatment.

I, the undersigned, have insurance coverage with the above named carriers, and assign directly to:

HARLEY J. WILLIAMS, D.M.D. all dental benefits
Name of Doctor

including any major medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information to secure the payment of benefits.

Date _____ Signed _____

PLEASE COMPLETE BOTH SIDES (OVER)