

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 # _____
Social Security # _____

NAME _____
First Middle Last

Home Address _____
Street City State Zip Phone _____

Status (✓): () Married () Single () Divorced () Widowed () Minor Cell Phone _____

Employed by _____
Parent's information if a minor WorkPhone _____

Work Address _____
City Occupation _____

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

Employed by _____
Occupation _____

Work Address _____
Phone _____

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

Address _____
Street City State Zip Phone _____

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

RESPONSIBLE PARTY FOR PAYMENT

Date of Birth _____

NAME _____
First Middle Last Social Security # _____

RELATIONSHIP TO PATIENT _____

Home address _____
Street City State Zip Phone _____

Employed by _____
Occupation _____

Work address _____
Phone _____

INSURANCE INFORMATION

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

ADDRESS _____ ADDRESS _____

NAME OF EMPLOYER _____ NAME OF EMPLOYER _____

SUBSCRIBER NAME _____ SUSCRIBER NAME _____

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:

STEVEN M. 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)

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 value 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

- Panic attacks
- Congenital heart disease
- Cardiovascular: heart attack,
coronary insufficiency, high blood
pressure, arteriosclerosis
coronary by pass, prosthetic valve,
stroke, mitral valve prolapse
- Shortness of breath

YES NO

- Abnormal bleeding
- Asthma, hay fever, sinus trouble
- Hives or skin rash
- Diabetes
- Hepatitis, jaundice, or liver disease
- Stomach ulcers
- Cancer/radiation therapy
- Frequent infections, fatigue

YES NO

- Kidney trouble
- Tuberculosis, lung disease
- Fainting spells or epilepsy
- Temporomandibular joint problems
- Psychiatric treatment
- Acquired Immune Deficiency Syndrome (AIDS)
- Joint prosthesis (artificial knee, hip, ect.)
- Venereal 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 dental procedures deemed necessary or advisable to be performed by Dr. Steven M. Williams and any assistant required. I agree to the use of local anesthesia and/or oral sedation, depending upon the judgment of the doctor. Complications of root canal therapy, dental implant surgery, tooth extractions, 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.

If Dr. Williams recommends that I should have root canal therapy, I understand that this a procedure done in order to retain a tooth which may otherwise require extraction. Although root canal therapy has a very high degree of clinical success, occasionally, a tooth which has had root canal therapy may require additional treatment, surgery, or even extraction. Dental implant surgery and/or extraction of teeth may be the recommended treatment by Dr. Williams. I understand that these elective procedures can either replace missing teeth or remove an infected or painful tooth. During or after these treatments, there is the possibility of instrument breakage within root canals, perforations, damage to bridges, existing fillings, crowns, or porcelain veneers, loss of tooth structure in gaining access to canals, and fractured teeth. Other treatment choices include no treatment, waiting for more definitive symptoms to develop, or 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 possibly 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.

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.)