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 ( ) Widowed ( ) Minor Cell Phone _____

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

Work Address _____ Occupation _____
City

SPOUSE/GUARDIAN _____ 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

RELATIONSHIP TO PATIENT _____

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 _____

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		YES	NO		YES	NO	
❑	❑	Panic attacks	❑	❑	Abnormal bleeding	❑	❑	Kidney trouble
❑	❑	Congenital heart disease	❑	❑	Asthma, hay fever, sinus trouble	❑	❑	Tuberculosis, lung disease
❑	❑	Cardiovascular: heart attack,	❑	❑	Hives or skin rash	❑	❑	Fainting spells or epilepsy
		coronary insufficiency, high blood	❑	❑	Diabetes	❑	❑	Temporomandibular joint problems
		pressure, arteriosclerosis	❑	❑	Hepatitis, jaundice, or liver disease	❑	❑	Psychiatric treatment
		coronary by pass, prosthetic valve,	❑	❑	Stomach ulcers	❑	❑	Acquired Immune Deficiency Syndrome (AIDS)
		stroke, mitral valve prolapse	❑	❑	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 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.)