



welcome

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Beautiful Healthy Smiles

1 About You

Today's Date: ____/____/____ File # _____

Patient Name: _____
Last First MI

What you prefer to be called: _____

Birthdate: ____/____/____ Age: ____ SS# ____-____-____

Mailing Address: _____
City State Zip

Home # _____ Work # _____

Cell # _____ Email Address: _____

Referred By: _____

Employer: _____

Employer Address: _____
City State Zip

Status: Minor Single Married Partner

Spouse/Partner Name: _____

Do you have children? Yes No How Many? _____

2 Insurance Information

Primary Dental Insurance
Insured person's name: _____

Relation: Self Spouse/Partner Parent/Guardian

Insured Person's Employer: _____

Insured's SS # ____-____-____

Dental Insurance Co. _____ Phone# _____

Address: _____
City State Zip

Insurance ID # _____ Group # _____

Secondary Dental Insurance
Insured person's name: _____

Relation: Self Spouse/Partner Parent/Guardian

Insured Person's Employer: _____

Insured's SS # ____-____-____

Dental Insurance Co. _____ Phone# _____

Address: _____
City State Zip

3 Account Information

Person responsible for account
Name: _____

Relation: Self Spouse/Partner Parent/Guardian

Billing Address: _____
City State Zip

Home # _____ Work # _____

SS # ____-____-____ Drivers License# _____

Payment Method: Cash Check MC/Visa

I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand that I am solely responsible for any balance not paid by my insurance company.

4 In Event of Emergency

Whom should we contact? _____ Relation: _____

Address: _____

Home # _____ Work # _____ Cell # _____

Who is your medical doctor? _____ Phone# _____



Patient Name: _____ **Today's Date:** _____

Reason for today's visit: Exam Emergency Consultation **Are you in pain?** Yes No **How Long?** _____

Please indicate any of the following problems:

- | | | |
|---|---|--|
| <input type="checkbox"/> Discomfort, clicking or popping in jaw | <input type="checkbox"/> Lost/Broken Filling(s) | <input type="checkbox"/> Stained teeth |
| <input type="checkbox"/> Red, swollen or bleeding gums | <input type="checkbox"/> Teeth Grinding | <input type="checkbox"/> Locking Jaw |
| <input type="checkbox"/> Sensitive tooth, teeth or gums | <input type="checkbox"/> Ringing in Ears | <input type="checkbox"/> Bad breath |
| <input type="checkbox"/> Blisters/Sores in or around the mouth | <input type="checkbox"/> Broken/Chipped tooth | <input type="checkbox"/> Other _____ |

Last Dental Exam: _____ Last Dental X-Rays: _____ Previous Dentist: _____ Phone: _____

Do you require Pre-medication? Yes No Don't Know

Times a day you brush? _____ Times a week you floss? _____ Type of toothbrush you use? Soft Medium Hard

How would you rate your smile 1 2 3 4 5 6 7 8 9 10 Would you like to change anything? _____

Medical History

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health-problems that you may have or medication that you may be taking could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

- | | |
|--|---|
| Are you under a physician's care now? <input type="checkbox"/> Yes <input type="checkbox"/> No | Are you on a special diet? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Have you ever been hospitalized or had a major operation? <input type="checkbox"/> Yes <input type="checkbox"/> No | Do you use Tobacco? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Have you ever had a head or neck injury? <input type="checkbox"/> Yes <input type="checkbox"/> No | If yes, how long? _____ How much per day? _____ |
| Are you taking any medications, pills, or drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No | |

Please list all medications _____

Are you allergic to the following? Aspirin Penicillin Acrylic Metal Latex Local Anesthetics Other _____

Women: Are you: Pregnant / trying to get pregnant? Nursing Taking oral contraceptives?

Do currently have or have you ever had any of the following? Please all that apply

- | | | | | |
|--|--|--|---|---|
| <input type="checkbox"/> AIDS/HIV Positive | <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Alzheimer's Disease | <input type="checkbox"/> Cold Sores/Fever Blisters | <input type="checkbox"/> Genital Herpes | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Anaphylaxis | <input type="checkbox"/> Congenital heart Disorder | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Cortisone Medicine | <input type="checkbox"/> Heart Attack/Failure* | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Spina Bifida |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Murmur* | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Stomach/Intestinal Disease |
| <input type="checkbox"/> Artificial Heart Valve* | <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Heart Pace Maker* | <input type="checkbox"/> Mitral Valve Prolapse* | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Artificial joint* | <input type="checkbox"/> Easily Winded | <input type="checkbox"/> Heart Trouble/Disease | <input type="checkbox"/> Pain in Jaw Joints | <input type="checkbox"/> Swelling of Limbs |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Parathyroid Disease | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Hepatitis B or C | <input type="checkbox"/> Radiation Treatments | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Breathing Problem | <input type="checkbox"/> Excessive Thirst | <input type="checkbox"/> Herpes | <input type="checkbox"/> Recent Weight Loss | <input type="checkbox"/> Tumors or Growths |
| <input type="checkbox"/> Bruise easily | <input type="checkbox"/> Fainting Spells/Dizziness | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Renal Dialysis | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> Frequent Cough | <input type="checkbox"/> Hives or Rash | <input type="checkbox"/> Rheumatic Fever* | <input type="checkbox"/> Venereal Disease |

Have you ever had any serious illness not listed above? Yes No If yes please list: _____

** May require medication*

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

× _____

Signature of patient, parent or guardian

Date

Medical Updates

I have read my Medical History and confirm that it adequately states past and present conditions.

