



**Steven D. Williams**  
D.D.S.



**Confidential Information**

Date: \_\_\_\_\_

Name: \_\_\_\_\_ Birthday: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ St. \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Wk Phone \_\_\_\_\_ Ext. \_\_\_\_\_ Cell \_\_\_\_\_

E-mail: \_\_\_\_\_ Marital Status: \_\_\_\_\_ S.S.# \_\_\_\_\_

Occupation: \_\_\_\_\_ Present Employer: \_\_\_\_\_

Business Address: \_\_\_\_\_ City: \_\_\_\_\_ St. \_\_\_\_\_ Zip: \_\_\_\_\_

Name of Spouse: \_\_\_\_\_ Occupation: \_\_\_\_\_

Emergency Contact (if other than spouse): \_\_\_\_\_ Phone: \_\_\_\_\_

Do you have primary dental insurance? Yes No Company? \_\_\_\_\_

Do you have secondary insurance? Yes No Company? \_\_\_\_\_

If you have dental insurance, please give your card to the receptionist to copy.

Whom may we thank for referring you to our office? \_\_\_\_\_

**PLEASE READ BELOW BEFORE SIGNING**

We are dedicated to helping you obtain optimum dental health; in order to do so please note the following.

**Appointments:** When you make an appointment in our office, we reserve that time specifically for you. If you are unable to keep your appointment, please provide at least 24 hours notice. We understand that unforeseen circumstances arise which may require changing an appointment, however, repeated cancellations may result in a fee charged to your account.

**Insurance:** If you have dental insurance we will cooperate in every reasonable way. You are expected to pay your portion of the fee at the time of service. If your insurance does not cover your services you are responsible for the entire balance. Delays in payment by the insurance company are not acceptable reasons for delay of payment of your account. Any unpaid balance after 60 days is your responsibility to pay. Accounts turned over to a collection agency will be subject to a collection fee. As a courtesy, we will prepare the necessary forms to help you obtain benefits from your insurance company, but the only contract exists between your insurance company and you.

There will be a 1.00% per month (12% per annum) service charge on all balances over 60 days old.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**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?  Yes  No If yes, please explain: \_\_\_\_\_

Have you ever been hospitalized or had a major operation?  Yes  No If yes, please explain: \_\_\_\_\_

Have you ever had a serious head or neck injury?  Yes  No If yes, please explain: \_\_\_\_\_

Are you taking any medications, pills, or drugs?  Yes  No If yes, please explain: \_\_\_\_\_

Do you take, or have you taken, Phen-Fen or Redux?  Yes  No \_\_\_\_\_

Are you on a special diet?  Yes  No \_\_\_\_\_

Do you use tobacco?  Yes  No \_\_\_\_\_

Do you use controlled substances?  Yes  No \_\_\_\_\_

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

Are you allergic to any of the following? \_\_\_\_\_

Aspirin  Penicillin  Codeine  Acrylic  Metal  Latex  Local Anesthetics

Other If yes, please explain: \_\_\_\_\_

Do you have, or have you had, any of the following? \_\_\_\_\_

- |   |  |  |  |   |
|---|--|--|--|---|
| <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/Gout         | <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           |
| <input type="checkbox"/> Chemotherapy           | <input type="checkbox"/> Frequent Diarrhea         | <input type="checkbox"/> Hypoglycemia          | <input type="checkbox"/> Rheumatism            | <input type="checkbox"/> Yellow Jaundice            |

Have you ever had any serious illness not listed above?  Yes  No If yes, please explain: \_\_\_\_\_

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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 \_\_\_\_\_

# DENTAL HISTORY

Patient Name \_\_\_\_\_

Patient Account No. \_\_\_\_\_

Medical Alert \_\_\_\_\_

*Welcome! So that we may provide you with the best possible care  
please complete both sides of this medical/dental history form.  
All information is completely confidential.*

What is the reason for your visit today? \_\_\_\_\_  
\_\_\_\_\_

Date of Last Dental Visit \_\_\_\_\_ Last Dental Cleaning \_\_\_\_\_ Last Full Mouth X-rays \_\_\_\_\_  
What was done at your last dental visit? \_\_\_\_\_  
\_\_\_\_\_

Previous Dentist's Name \_\_\_\_\_  
Address \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Telephone \_\_\_\_\_

How often do you have dental examinations? \_\_\_\_\_  
How often do you brush your teeth? \_\_\_\_\_ How often do you floss? \_\_\_\_\_  
What other dental aids do you use? (Interplak, toothpick, etc.) \_\_\_\_\_

Do you have any dental problems now? Yes No  
If yes, please describe: \_\_\_\_\_

**Are any of your teeth sensitive to:**  
Hot or cold? Yes No  
Sweets? Yes No  
Biting or Chewing? Yes No  
Have you noticed any mouth odors or bad tastes? Yes No  
Do you frequently get cold sores, blisters or  
any other oral lesions? Yes No

**Do your gums bleed or hurt?** Yes No  
Have your parents experienced gum disease  
or tooth loss? Yes No  
Have you noticed any loose teeth or change  
in your bite? Yes No  
Does food tend to become caught in between  
your teeth? Yes No

If yes, where? \_\_\_\_\_

**Do you:**  
Clench or grind your teeth while awake or asleep? Yes No  
Bite your lips or cheeks regularly? Yes No  
Hold foreign objects with your teeth?  
(pencils, pipe, pins, nails, fingernails) Yes No  
Mouth breath while awake or asleep? Yes No  
Have tired jaws, especially in the morning? Yes No  
Smoke/chew tobacco? Yes No

**Have you ever had:**  
Orthodontic treatment? Yes No  
Oral surgery? Yes No  
Periodontal treatment? Yes No  
Your teeth ground or the bite adjusted? Yes No  
A bite plate or mouth guard? Yes No  
A serious injury to the mouth or head? Yes No  
If so, please describe, including cause \_\_\_\_\_  
\_\_\_\_\_

**Have you experienced:**  
Clicking or popping of the jaw? Yes No  
Pain? (joint, ear, side of face) Yes No  
Difficulty in opening or closing the mouth? Yes No  
Difficulty in chewing on either side of the mouth? Yes No  
Headaches, neckaches or shoulder aches? Yes No  
Sore muscles (neck, shoulders)? Yes No

**Are you satisfied with your teeth's appearance?** Yes No  
Would you like to keep all of your teeth all of your life? Yes No  
  
**Do you feel nervous about having dental treatment?** Yes No  
If so, what is your biggest concern?  
\_\_\_\_\_  
  
**Have you ever had an upsetting dental experience?** Yes No  
If yes, please describe \_\_\_\_\_  
\_\_\_\_\_

Is there anything else about having dental treatment that you would like us to know? Yes No  
If yes, please describe \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



## Smile Assessment Form

Please consider each statement carefully and circle YES or NO. Dr. Williams and members of his dental team will discuss your responses with you in confidence.

1. I am concerned about the appearance of my teeth or my smile. YES NO
2. I am concerned about the whiteness/lack of whiteness of one or more of my teeth. YES NO
3. I am concerned about the position or angle of one or more of my teeth. YES NO
4. I am concerned about the shape of one or more of my teeth. YES NO
5. In social situations, I am sometimes embarrassed by my teeth. YES NO
6. There are some things about my upper front teeth that I would like to change. YES NO
7. There are some things about my lower front teeth that I would like to change. YES NO
8. I have old fillings or previous dental treatment that is no longer satisfactory to me. YES NO
9. I am missing one or more of my teeth. YES NO
10. I am interested in learning more about esthetic dentistry. YES NO

Please use the space below to indicate any other problems, concerns, or questions. We will address your dental concerns and present you with the best treatment options. Thank you!

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