



visit: [drmikewilliams.com](http://drmikewilliams.com)

954 4SMILES or 954 476 4537

ABOUT YOU

Date \_\_\_/\_\_\_/\_\_\_ Name \_\_\_\_\_ I prefer to be called \_\_\_\_\_
Address: Street \_\_\_\_\_
City/State Zip/ Country \_\_\_\_\_
Birth date: \_\_\_/\_\_\_/\_\_\_ Social Security # \_\_\_\_\_ Sex: M F Marital Status: M S D W
Driver's License # \_\_\_\_\_ State \_\_\_\_\_ Valid Thru \_\_\_\_\_
Home Phone # ( ) \_\_\_\_\_ Cell Phone # ( ) \_\_\_\_\_ Work Phone # ( ) \_\_\_\_\_
E-mail address ( email info for our office use only) \_\_\_\_\_
Spouse Name \_\_\_\_\_ Spouse's Place of Employment \_\_\_\_\_
Person responsible for account (if child, put parent's name) \_\_\_\_\_
Address (if different from above): Street \_\_\_\_\_
City/State/Zip/ Country \_\_\_\_\_
Employer \_\_\_\_\_ Position \_\_\_\_\_ Student ? Y N Where? \_\_\_\_\_
Address at Work: \_\_\_\_\_ City/State Zip \_\_\_\_\_
Name of nearest relative not in same household: \_\_\_\_\_ Relationship \_\_\_\_\_
Address: \_\_\_\_\_ City/State/Zip/ Country \_\_\_\_\_
Relative's Contact phone number ( ) \_\_\_\_\_
Whom may we thank for referring you to our office? \_\_\_\_\_

MEDICAL HISTORY

General Health (Circle)...Excellent...Good...Fair... Poor. Last complete physical \_\_\_\_\_
Physician's Name \_\_\_\_\_ Phone number \_\_\_\_\_
Are you taking any medication for any purpose daily now (including aspirin)? Y..... N
Names of medications: \_\_\_\_\_ purpose \_\_\_\_\_
Names of medications: \_\_\_\_\_ purpose \_\_\_\_\_
Names of medications: \_\_\_\_\_ purpose \_\_\_\_\_
Are you allergic to the following? Penicillin..... Codeine..... Latex ..... "Novocaine" .....
Allergies to other medications/ foods/ substances? \_\_\_\_\_
Do you need pre-medication for dental treatment? ...Y...N... What medication? \_\_\_\_\_
Please circle Yes or No if you have or have you been treated for the following?
Y N Heart disease, stroke.....Y N Abnormal blood pressure
Y N Infective endocarditis, Y N congenital heart disease, heart transplant
Y N Prolonged bleeding..... Y N Prostheses (e.g. heart valve, artificial hip, knee, etc.)
Y N Hepatitis, jaundice.....Y N Thyroid disease, endocrine disorders, ulcers
Y N Fainting spells, epilepsy..... Y N Lung disease, emphysema
Y N Diabetes..... Y N Arthritis, joint diseases
Y N Anemia..... Y N Asthma or hay fever, sinus trouble
Y N Allergies..... Y N AIDS, gonorrhea, syphilis, herpes
Y N Glaucoma..... Y N Radiation treatment
Y N Cancer..... Y N Pregnant
Y N Other illness?.... Describe \_\_\_\_\_
Notes: \_\_\_\_\_

I acknowledge that all information contained herein is true and correct and give my permission to verify any of the information provided. I the undersigned (patient or legally responsible party), have reviewed the HIPA Privacy Policy Notice available for the office of Dr. Michael D. Williams.

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



**Your Dental History**

What is your immediate dental concern? \_\_\_\_\_  
 Name and address of previous dentist \_\_\_\_\_  
 Do you have or have you had? Please circle Yes or No.  
 Y N Problems with previous dental treatment or special concerns you would like to discuss? \_\_\_\_\_  
 Y N Treatment by any dental specialist (e.g. Periodontist, Endodontist, Oral surgery, Orthodontics, Other) When and for what purpose? \_\_\_\_\_  
 Y N Teeth whitening: when and what method? \_\_\_\_\_  
 Y N Cosmetic dentistry: when, what procedure? \_\_\_\_\_  
 Y N Dental pain: where, when or what causes the pain? \_\_\_\_\_  
 Y N Gum disease, Growths, bleeding of gums, unpleasant taste or odor- where? \_\_\_\_\_  
 Y N Snoring, Sleep Apnea? Y N participate in sports? Type \_\_\_\_\_  
 Y N A bad reaction to dental anesthetics? Y N Nitrous Oxide or gas for dental treatment?  
 Y N Do you have TMJ pain, headaches, jaw pain, jaw clicking, facial pain, clenching, grinding etc.?  
 Y N Do or did your parents or siblings have Gum disease, Dentures, Problems with cavities?  
 Y N Other family history.

**Your smile**

Please circle the following if you would like help with your smile. My teeth are .. Or have...

1. NOT WHITE, dark, discolored or stained teeth.	2. NOT STRAIGHT, crooked teeth, or a bad orthodontics
3. SPACES, gaps between your teeth.	4. SHORT TEETH, teeth that are worn down.
5. TEETH TOO LARGE or pointy or flat.	6. POOR RESULT from previous dental work or veneers.
7. OLD DENTAL WORK, that does not match.	8. GUMS that show too much when you smile.
9. DARK LINES around old crowns.	10. BLACK METAL FILLINGS with mercury.
11. MISSING TEETH.	12. Other _____

What do you expect from your new smile? \_\_\_\_\_.

**Photography, video, images, and testimonials**

A part of your diagnosis and care we routinely record images of your smile and other dental conditions. Will you please allow us to use your image by agreeing to the following? For value received, I consent and authorize Dr. Michael D. Williams to use my image and or testimonial letter, with or without my name, for dental health diagnosis, smile imaging, patient education, publication, research, promotion, professional lectures, or any other lawful purpose and I release and forever discharge him from any claim, demands or liability on account of such use or for the quality of the image reproduction or text.  
 Signature \_\_\_\_\_ Date \_\_\_\_\_

**Dental Insurance Information**

#1 Insurance Company (Primary Carrier) Ins. Co. \_\_\_\_\_ Phone# \_\_\_\_\_  
 Name of Insured \_\_\_\_\_ DOB \_\_\_\_\_ S,S.# \_\_\_\_\_  
 #2 Insurance Company Ins. Co. \_\_\_\_\_ Phone# \_\_\_\_\_  
 Name of Insured \_\_\_\_\_ Relationship to Insurance Holder \_\_\_\_\_

**Payment Options**

Cash, Check, Visa, Mastercard, American Express, Dental Fee Plan, Care Credit  
 I, the undersigned (patient or legally responsible party), authorize dental treatment to be rendered by the dentist and his staff, and I assume all financial responsibility for treatment given, services rendered and all associated costs incurred as a result of my treatment. I agree that all information contained herein is true and correct.  
 Signature \_\_\_\_\_ Date \_\_\_\_\_