

ALL PATIENT INFORMATION WILL BE KEPT STRICTLY CONFIDENTIAL

MIE I MILE I GIII OI						
Male Female Married Single Child Other Email Address:						
If Married Please write spouse name here:						
Social Security #: Date of Birth: DL #						
Phone (Home): Cell: Work:						
Address:						
Street Apt #:						
City State Zip Code						
Employer Name: Employer Ph #:						
If you are carrying dental insurance please list insurance carrier here:						
Referral Information Whom may we thank for referring you to our practice?						
AND A A STAN AND AND A STAN AND A						
HEALTH HISTORY						
Physician Name: Phone: Date last seen:						
 Are you now under the care of a physician? Yes No Have you been admitted to a hospital or needed emergency care in the past two years? Yes No Please list any medications you are currently taking: 						
Please list any food, drug or seasonal allergies:						
Have you ever been diagnosed or treated for any of the following (Circle all that apply)						
Heart Disease Psychiatric Jaundice Arthritis Sinus Trouble Treatment						
Heart Murmur High Blood Pressure Asthma Anemia Osteoporosis						
Tuberculosis Rheumatic/Scarlet Joint Replacement Diabetes HIV/Hepatitis Fever						
Epilepsy Immune System Angina Fainting Thyroid Trouble Disorders						

- Any other disease, condition, or problem not listed above? Yes No Explain:
- Do you smoke or chew tobacco? Yes No
- (Women Only) Are you pregnant? Yes No
- Have you taken any osteoporosis/bisphosphonate drugs in the past 10 years? (ie Fosamax, Actonel, Alendronate)

Health Questionnaire Consent & Financial Policy I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that Dr. Williams and his staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold Dr. Williams or his staff responsible for any action they may or may not take because of errors or omissions that I may have made in the completion of this form. Since a change of medical condition or medications can affect dental treatment, I understand the importance of and agree to notify Dr. Williams of any changes at any subsequent appointment. I authorize Dr. Williams to perform all general preventative and operative treatment procedures necessary to maintain my oral and dental health including administration of local or topical anesthetics, nitrous oxide, or prescription drugs for pain, infection, or medical condition. All dental services must be paid for at the time services are rendered. If you have insurance, your portion must be paid for at the time of service, unless financial arrangements are made prior to treatment. Even though you have insurance, you are personally responsible for payment of dental services whether or not your insurance pays for claim. This agreement also Pinecrest Dental to share patient information with third party insurance companies in order to complete claims submission. Our office will gladly help prepare and submit the insurance forms of patients and will credit any such payments received from your insurance to the patient's account. However, this office cannot render services on the assumption that our charges will be paid in full by any insurance company. Please allow 24 hours notice for appointment cancellations, broken appointments without notification are subject to a \$40 fee. Terms: Net 30 days. Interest at the rate of 1.5% per month (18% annuall	•]	Do you have any health p	problems that need further clarify		
While seated in the dental chair do you prefer Listening To Music Talking Silence Other Do you brush your teeth daily? (circle) Yes No How may days per week do you floss? How much soda pop or sports drinks do you consume every week? Have you ever had any complications following dental treatment? Yes No If so what? Are you having pain or sensitivity at this time? Yes No Explain: Are you unknows or apprehensive about dental treatment? Yes No Explain: Have you recently whitened your teeth? Yes No Explain: Have you recently whitened your teeth? Yes No When: Have you ever had an unusual reaction to dental anesthetic? Yes No Have you ever had any of the following? (Circle any that apply) Bleeding/Sore Gums Food Trapped Between Teeth Periodontal/Gum Treatment Clinching/Grinding Teeth Loose/Shifting Teeth Extraction Complications Orthodontic Treatment (Braces) TMD/Clicking Jaw Sensitivity to Hot/Cold Facial/Dental Tra Health Questionnaire Consent & Financial Policy I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that Dr. Williams and his staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold Dr. Williams or his staff responsible for any action they may or may not take because of errors or omissions that I may have made in the completion of this form. Since a change of medical condition or medications can affect dental treatment, I understand the importance of and agree to notify Dr. Williams of any changes at any subsequent appointment. I authorize Dr. Williams to perform all general preventative and operative treatment procedures necessary to maintain my oral and dental health including administration of local or topical anesthetics, nitrous oxide, or prescription drugs for pain, infection, or medical condition. All dental services must be paid for at the time		D (01) 1) 1	DENTAL HISTOR		
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(and and 10) I and Consultan Name B' 41 1 4	Signatu	re of Patient or Legal	l Guardian	Date	
	(1	10) 1. 10 "	n Name Rirthdate		SSN SSN



INFORMED CONSENT TO PHOT	TOGRAPH
I,	, do hereby give consent for Dr. Tyler
(Patient/Legal Guardian)	
Williams to take and/or display pho	otograph(s) of my smile, specifically my teeth and lips. The
photograph will be used for a recor	d of my dental care, and may be used for
educational purposes in lectures, de	emonstrations to other patients, and professional
publications and/or marketing. My	personal information, name, and identity will be kept
strictly confidential.	
Signature:	Date:
Relation to Patient: (circle one)	
Patient Legal Guardian	
Please provide an email address if y	you'd like us to email you a copy of your
photos:	