Williams & Pearce Family Dental

HEALTH HISTORY

Adult Form

Date_____ Patient Name_____ Name you wish to be called_____
Physical Address_____Home Phone_____
City_____State_____Zip Code_____Work Phone_____
Mailing Address_____Cell Phone_____
City_____State_____Zip Code_____
Email Address:_____
Best Time and Place to Reach You_____
Sex: ☐Male ☐Female Age_____Birthdate_____ ☐Single ☐Married ☐Widowed ☐Separated ☐Divorced
Patient SS#_____ Occupation_____ Employer_____
Employer Address_____ Employer Phone_____
Spouse name_____ Birthdate_____ SS#_____
Occupation_____ Spouse's Employer_____

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IN CASE OF EMERGENCY PLEASE CONTACT (Someone not living with you)
Name_____Relationship to you_____
Address and Phone Number of Emergency Contact Person_____

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Whom may we thank for referring you?_____

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Who is responsible for this account?_____Relationship to patient_____
Insurance Company_____Group #_____
Subscriber's name_____Subscriber's ID#_____
Subscriber's Birthdate_____ Relationship to Patient_____ Is patient covered by additional Insurance? ☐Yes ☐No
Insurance Company_____Group#_____

ASSIGNMENT AND RELEASE I, the undersigned certify that I (or my dependent) have insurance coverage with ***the above insurance company*** and assign directly to doctor otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. ***Patient portion due at appointment.*** I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____ _____
Responsible Party Signature Relationship Date

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DENTAL HISTORY

Reason for today's visit_____
Former Dentist_____City/State_____
Date of last dental visit_____Date of last dental X-rays_____

Bad Breath	☐Yes ☐No	Blisters on lips or mouth	☐Yes ☐No
Burning sensation on tongue	☐Yes ☐No	Cigarette/Pipe/Cigar smoking	☐Yes ☐No
Clicking/popping jaw	☐Yes ☐No	*Have you ever attempted to quit?*	☐Yes ☐No
Pain/Discomfort in jaw joint	☐Yes ☐No	Chewing Tobacco	☐Yes ☐No
Periodontal Disease	☐Yes ☐No	*Have you ever attempted to quit?*	☐Yes ☐No
Loose teeth or broken fillings	☐Yes ☐No	Fingernail Biting	☐Yes ☐No
Pain around ear	☐Yes ☐No	Grinding Teeth	☐Yes ☐No
Sores or growths in mouth	☐Yes ☐No	Lip or cheek biting	☐Yes ☐No
Sensitivity to	☐Yes ☐No	Orthodontic treatment (*Braces*)	☐Yes ☐No
☐*Heat* ☐*Cold* ☐*Sweets* ☐*Biting*	☐Yes ☐No	Gums Swollen	☐Yes ☐No
Bleeding Gums	☐Yes ☐No	Do you like your smile	☐Yes ☐No
Dry Mouth	☐Yes ☐No	Have you ever had a serious/difficult	
Mouth Breathing	☐Yes ☐No	problem associated with dental work?	☐Yes ☐No
How often do you floss?_____		Do you drink fluorinated water or take	
How often do you brush?_____		fluoride supplements?	☐Yes ☐No
Type of bristles: ☐*Hard* ☐*Medium* ☐*Soft*			

Primary Care Physician's Name:_____ Date of last visit:_____

Specialist's Name *(Cardiac, Orthopedic, Oncologist, Etc.)*:_____ Date of last visit:_____

Please check Yes or No to indicate if you have had any of the following:

AIDS/HIV Positive ☐Yes ☐No
Anemia ☐Yes ☐No
Arthritis, Rheumatism ☐Yes ☐No
Asthma ☐Yes ☐No
Back Problems ☐Yes ☐No
Bleeding Abnormal ☐Yes ☐No
Tuberculosis ☐Yes ☐No
Blood Disease ☐Yes ☐No
Cancer: Type_____ ☐Yes ☐No
Chemotherapy ☐Yes ☐No
Radiation Treatment ☐Yes ☐No
Chemical Dependency ☐Yes ☐No
Circulatory Problems ☐Yes ☐No
Cortisone Treatments ☐Yes ☐No
Cough, Persistent/bloody ☐Yes ☐No
Diabetes: Type:_____ ☐Yes ☐No
☐*Pills* ☐*Injection* ☐*Pump*
Epilepsy ☐Yes ☐No
Fainting or Dizziness ☐Yes ☐No
Glaucoma ☐Yes ☐No
Organ Transplant ☐Yes ☐No
*Year:*_____ *Type:*_____

Headaches ☐Yes ☐No
Heart Problems: ☐Yes ☐No
*Type:*_____
Congenital Heart Lesions ☐Yes ☐No
Heart Murmur ☐Yes ☐No
Mitral Valve Prolapse ☐Yes ☐No
Pacemaker ☐Yes ☐No
Heart Attack: ☐Yes ☐No
*Date:*_____
High / Low Blood Pressure ☐Yes ☐No
*Meds:*_____
Hepatitis: ☐Yes ☐No
*Type*_____
Oral Herpes ☐Yes ☐No
Jaundice ☐Yes ☐No
Jaw Pain ☐Yes ☐No
Joint Replacement ☐Yes ☐No
*Year:*_____ *Type:*_____

Kidney Disease ☐Yes ☐No
Liver Disease ☐Yes ☐No
Nervous Problems ☐Yes ☐No
Psychiatric Care ☐Yes ☐No
Respiratory Disease ☐Yes ☐No
Shortness Of Breath ☐Yes ☐No
Sinus Trouble ☐Yes ☐No
Skin Rash ☐Yes ☐No
Special Diet ☐Yes ☐No
Stroke: *Year*_____ ☐Yes ☐No
Swelling Of Feet Or Ankles ☐Yes ☐No
Swollen Neck Glands ☐Yes ☐No
Thyroid Problems ☐Yes ☐No
Ulcer ☐Yes ☐No
Tumor/Growth On Head Or Neck ☐Yes ☐No
Venereal Disease ☐Yes ☐No
Any Hosiptal Stays ☐Yes ☐No
*Explain:*_____
Other Conditions Not Listed:
_____
_____
_____

Women: Are your pregnant? ☐**Yes** ☐**No** * Due Date:_____
Are you nursing: ☐**Yes** ☐**No** * Are you taking birth control pills? ☐**Yes** ☐**No**

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MEDICATIONS

Please list medications you are currently taking:

_____
_____
_____

Pharmacy Name_____

ALLERGIES

☐ No Known Allergy
☐ Aspirin
☐ Barbiturates (sleeping pills)
☐ Codeine
☐ Local Anesthetic
☐ Latex
☐ Iodine
☐ Penicillin
☐ Sulfa
☐ Other _____

I understand I am responsible for my account balance regardless of my insurance. I also understand that my insurance is an agreement between my insurance company and myself. WP Dental will prepare and submit necessary forms to help you obtain your benefits.

I understand that I may be charged a 1% finance charge per month (12% annually) if my balance goes beyond 60 days from date of service not from date the insurance company pays my benefits. ***Patient portion due at appointment.***

I give permission for my dentist and clinical team to take any necessary radiographs, study models, and photographs to make a complete diagnosis of my dental needs. I also give permission for my dentist and dental team to use my photographs for in-office patient education.

I consent to the use and disclosure of my protected health information to obtain payment information in connection with my dental claims.

_____ _____

Patient's Signature Date

(I have read, agree to, and understand the statements listed above.)