



B. Edward Williams, DMD, LLC
D. Hamilton Sims, DMD
2101 SE 39th Ave.
Portland, Oregon 97214
503-234-6148

welcome

Beautiful Healthy Smiles

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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? _____

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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

Initials
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.

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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

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In Event of Emergency

Whom should we contact? _____ Relation: _____

Address: _____

Home # _____ Work # _____ Cell # _____

Who is your medical doctor? _____ Phone# _____

Please Continue on Back

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? ☐ Yes ☐ No Are you on a special diet? ☐ Yes ☐ No
 Have you ever been hospitalized or had a major operation? ☐ Yes ☐ No Do you use Tobacco? ☐ Yes ☐ No
 Have you ever had a head or neck injury? ☐ Yes ☐ No If yes, how long? _____ How much per day? _____
 Are you taking any medications, pills, or drugs? ☐ Yes ☐ 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.
