WILLIAMS
DENTISTRY
BRANDON & AMY WILLIAMS, DDS
EXTRAORDINARY DENTISTRY. EXCEPTIONAL CARE.

ACQUAINTANCE FORM

Date _____

Patient Name_____Date of Birth_____ Single____Married____
Address_____ City_____ State____ Zip_____
Home Phone_____ Cell Phone_____ Work Phone_____
Social Security Number_____ Employer_____
Email Address_____
Whom may we thank for referring you?_____
Person responsible for account_____
Address (if different from your own)_____
Spouse's Name_____ Employer_____
Spouse's Daytime Phone Number_____
Dental Insurance Company_____ Group #_____
Name of Policy Holder_____ Policy Holder Date of Birth_____
Policy Holder's Social Security Number or Insurance ID Number_____
Policy Holder's Employer _____
Year of last dental appointment_____ What was done? _____

MEDICAL HISTORY

Physician's Name_____ Last Visit_____
Are you being treated by a physician now? Yes_____ No_____
Are you taking any medications? No_____ Yes (please list)_____
_____
Are you allergic to any medications? No_____ Yes (please list)_____
_____
Any recent illness?_____

Please circle any of the following which you have had or have at the present:

AIDS/HIV	Emphysema	Leukemia	Shortness of Breath
Anemia	Epilepsy	Liver Disease	Sickle Cell Anemia
Arthritis/Rheumatism	Fainting or Dizziness	Low Blood Pressure	Sinus Trouble
Artificial Joints/Valves	Glaucoma	Metal Plates in Bones	Skin Rash
Asthma	Heart Murmur	Mitral Valve Prolapse	Stroke
Back Problems	Heart Problems	Nervous Disorders	Swollen Feet/Ankles
Blood Transfusions	Headaches	Pacemaker	Swollen Neck Glands
Cancer	Hepatitis A (infectious)	Prolonged Bleeding	Thyroid Disease
Chemical Dependency	Hepatitis B (serum)	Psychiatric Treatment	Tonsillitis
Chemotherapy	Herpes	Radiation	Trauma to Jaw Joints
Circulatory Problems	High Blood Pressure	Respiratory Disease	Tuberculosis
Cold Sores	High Cholesterol	Rheumatic Fever	Tumor/growth on head/neck
Cough	Jaw Pain	Scarlet Fever	Ulcers
Diabetes	Kidney Trouble	Seasonal Allergies	Unexplained weight loss
			Venereal Disease

Do you have any disease, condition or problem not listed?_____
Do you smoke or use smokeless tobacco? No_____ Yes_____ If yes, how much?_____

Women: Are you pregnant? Yes_____ No_____
Are you currently using birth control pills? Yes_____ No_____

My primary concern/reason for this visit:_____
_____

Dental History

These things are important to me about my dental health:_____
_____

Former Dentist's Name:_____ **City:**_____

Please circle one:

1. My mouth is:
(a) very comfortable
(b) moderately comfortable
(c) uncomfortable

2. I:
(a) think the appearance of my mouth is excellent
(b) think the appearance of my mouth is adequate
(c) wish I could change the appearance of my mouth

3. I:
(a) want to save my teeth at all costs
(b) prefer to keep my teeth if cost and time are reasonable
(c) expect to someday lose my teeth and have dentures

4. I:
(a) have set goals to achieve optimum oral health with a previous dentist
(b) want to set goals to achieve optimum oral health
(c) am not very interested in setting personal goals to achieve optimum oral health.

5. Where do you rate your smile on a scale of 0-10:

0 1 2 3 4 5 6 7 8 9 10

6. Where do you rate your oral health on a scale of 0-10:

0 1 2 3 4 5 6 7 8 9 10

7. What are some questions about dentistry and your oral health that you have never had adequately answered?_____
_____

As it relates to my medical history, all of the preceding answers are true and correct to the best of my knowledge. If I ever have a change in my health, or if my medicines change, I will inform Dr. Williams and their staff at my next dental appointment without fail.
(Insurance patients only: I authorize release of any information relating to dental insurance claims. I understand that I am responsible for all costs of dental treatment and that before credit is extended a credit report will be obtained.)

_____
Signature