Kenny Williams, DDS
Sedation, Cosmetic & General Dentistry

DATE: ______________________

WELCOME

The benefits of a happy, healthy smile are immeasureable! Our goal is to help you reach and maintain optimal oral health. Please fill out this form completely. The better we communicate, the better we can care for you.

ABOUT YOU

Email Address: ______________________

Name: ______________________

I prefer to be called: ______________ ☐ Male ☐ Female

Birthdate: ____/____/____ Age: ______ SS#: ______________

Home Address: ______________________ *Apt/Condo #*

____
City *State* *Zip*

☐ Single ☐ Married ☐ Partnered

☐ Divorced/Separated ☐ Widowed

Hm #: (____) ______________ Cell #: ______________

Wk#: (____) ______________ Ext: ______ DL#: ______________

Employer: ______________________

Employers Address: ______________________ *Apt/Condo #*

____
City *State* *Zip*

How long there? ________ Occupation: ______________

When & where are the best times to reach you? ______________

____

Whom may we thank for referring you? ______________

Other family members seen by us: ______________

Previous / Present Dentist: ______________
Please Circle

Person Responsible for Account: ______________

SPOUSE INFORMATION

His / Her Name: ______________________

Employer: ______________________

Wk#: (____) ______________ Ext: ______ DL#: ______________

Birthday: ____/____/____ DL #: ______________

Relative or Friend not living with you (for Emergency)

His / Her Name: ______________ Relation: ______________

Wk #: (____) ______________ Hm #: (____) ______________

INSURANCE

Primary Insurance

Dental Coverage: ☐ Yes ☐ No

Insurance Co. Name: ______________________

Insurance Co. Address: ______________________ *Apt/Condo #*

____
City *State* *Zip*

Insurance Co. Phone #: (____) ______________

Group # (Plan, Local or Policy #): ______________

Insured's Name: ______________ Relation: ______________

Insured's Birthday: ____/____/____ Insured's ID #: ______________

Insured's Employer: ______________________

Employer's Address: ______________________ *Apt/Condo #*

____
City *State* *Zip*

Secondary Insurance

Dental Coverage: ☐ Yes ☐ No

Insurance Co. Name: ______________________

Insurance Co. Address: ______________________ *Apt/Condo #*

____
City *State* *Zip*

Insurance Co. Phone #: (____) ______________

Group # (Plan, Local or Policy #): ______________

Insured's Name: ______________ Relation: ______________

Insured's Birthday: ____/____/____ Insured's ID #: ______________

Insured's Employer: ______________________

Employer's Address: ______________________ *Apt/Condo #*

____
City *State* *Zip*

Payment is due in full at the time of treatment
Unless prior arrangements have been approved.

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

____
Signature Date

P: (619) 469-4175
F: (619) 469-4196
info@kennywilliamsdds.com

5565 Grossmont Center Drive
Building #1, Suite 220
La Mesa, CA 91942

MEDICAL HISTORY

Do you have a personal physician: ☐ Yes ☐ No
Physician's Name: ______________________
Phone #: (____)______________ Date of last visit: __________
Your current physical health is : ☐ Good ☐ Fair ☐ Poor
Are you currently under the care of a physician? ☐ Yes ☐ No
Please explain:______________________
Do you smoke cigarettes, marijuana? ☐ Yes ☐ No
How much? Last Used?: ______________________
Have you ever used recreational drugs ☐ Yes ☐ No
(ex. Cocaine, Meth) Last Used?: ______________________
Have you had any metal rods, pins or implants? ☐ Yes ☐ No
Are you taking any prescription/over-the-counter drugs?
☐ Yes ☐ No
Please list each one: ______________________
Have you ever taken Fosamax, or any other bisphosphonate?
☐ Yes ☐ No

Have you been told that you snore or hold your breath while sleeping or wake up gasping for breath? ☐ Yes ☐ No

For Women:

Are you using a prescribed method of birth control? ☐ Yes ☐ No
Are you pregnant? ☐ Yes ☐ No Week #:______
Are you nursing: ☐ Yes ☐ No

Have you ever had any of the following diseases or medical problems:

Y	N	Abnormal bleeding / Hemophilia	Y	N	Herpes / Fever Blisters
Y	N	AIDS	Y	N	High Blood Pressure
Y	N	Alcohol / Drug Abuse	Y	N	HIV
Y	N	Anemia	Y	N	Hospitalized for Any Reason
Y	N	Arthritis	Y	N	Kidney Problems
Y	N	Artificial Bones / Joints / Valves	Y	N	Liver Disease
Y	N	Asthma	Y	N	Low Blood Pressure
Y	N	Blood Transfusion	Y	N	Lupus
Y	N	Cancer / Chemotherapy	Y	N	Mitrol Valve Prolapse
Y	N	Colitis	Y	N	Pacemaker
Y	N	Congenital Heart Defect	Y	N	Psychiatric Treatment
Y	N	Diabetes	Y	N	Radiation Treatment
Y	N	Difficulty Breathing	Y	N	Rheumatic / Scarlet Fever
Y	N	Emphysema	Y	N	Seizures
Y	N	Epilepsy	Y	N	Shingles
Y	N	Fainting Spells	Y	N	Sickle cell Disease / Traits
Y	N	Frequent Headaches	Y	N	Sinus Problems
Y	N	Glaucoma	Y	N	Stroke
Y	N	Hay Fever	Y	N	Thyroid Problems
Y	N	Heart Attack / Surgery	Y	N	Tuberculosis
Y	N	Heart Murmur	Y	N	Ulcers
Y	N	Hepatitis	Y	N	Venereal Disease

Please list any serious medical condition(s) that you've ever had:_____
____
____
____

Are you allergic to any of the following?

Y	N	Aspirin	Y	N	Erythromycin	Y	N	Penicillin
Y	N	Codeine	Y	N	Jewelry / Metals	Y	N	Tetracycline
Y	N	Dental Anesthetics	Y	N	Latex	Y	N	Other

Please list any other drugs / materials you are allergic to:__________
____
____
____
____

Our office is HIPAA Compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

DENTAL HISTORY

Why have you come to the dentist today? ______________________
____
Are you currently in pain? ☐ Yes ☐ No
Do you require antibiotics before dental treatment? ☐ Yes ☐ No
Your current dental health is : ☐ Good ☐ Fair ☐ Poor
Have you ever had a serious / difficult problem associated with any previous dental work? ☐ Yes ☐ No
Do you floss daily? ☐ Yes ☐ No
Brush Daily? ☐ Yes ☐ No
Type of bristles on your toothbrush? ☐ Hard ☐ Medium ☐ Soft
Have you ever had a gum treatment? ☐ Yes ☐ No
Do your gums ever bleed? ☐ Yes ☐ No Ever itch? ☐ Yes ☐ No
Have you ever had periodontal disease? ☐ Yes ☐ No
Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)? ☐ Yes ☐ No
Are your teeth sensitive to heat, cold or anything else? __________
Do you have any loose teeth? ☐ Yes ☐ No
Do you still have wisdom teeth? ☐ Yes ☐ No
Would you like fresher breath ☐ Yes ☐ No Whiter teeth? ☐ Yes ☐ No
Are you happy with the way your smile looks? ☐ Yes ☐ No
If not, what would you change? ______________________
____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any change in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment, with my informed consent.

____
Signature Date

OFFICE USE ONLY

I verbally reviewed the medical / dental information with the patient named herein.
Initials______________ Date______________
Doctor's Comments: ______________________
____
____
____
____