R. Renan Williams DDS

General Dentistry

5104 Eldorado Dr
North Richland Hills, TX 76180

Patient Information:

Patient's Name:____
First Middle Last Name Preference

Address:____
Street Apt# City State Zip

Home:____________________ Work:____________________ Cell:____________________
(Please provide all telephone numbers to contact you. There may be times when we need to reach you on short notice.)

Birth date:__________________ Male / Female Social Security #:____________________

Email Address:______________________________ Employer/School:____________________

Spouse's Name:________________________ Spouse's Employer:______________________

Spouse's Birth Date:_________________ Spouse's Social Security #:______________________

Emergency Contact:______________________ Home:_______________ Cell:_______________

How did you hear about our office:____

Responsible Party Information - ONLY IF different from above (Patient Information):

Self / Other: :____
First Middle Last Preference

If "Other," please complete: Relationship to patient:______________________

Are you currently a patient of the office: YES / NO Birth Date:__________________

Social Security #:_________________________ Driver's License:__________________

Home:____________________ Work:____________________ Cell:____________________
(Please provide all telephone numbers to contact you. There may be times when we need to reach you on short notice.)

Any benefits used this year:

Insurance Information – Insurance Company:______________________________ Yes / No

Insurance Phone #:_________________________ Group #:_________________

ONLY IF different from above (Patient Information):

Name of Insured:______________________________ Social Security #:__________________

Name of Employer:__________________________________ Birth Date:__________________

Broken Appointment Policy: Reserved appointment time in any dental office is limited and valuable. It is extremely important that all patients honor their reserved dental appointments. Failure to do so deprives our other patients from receiving needed dental care in a timely fashion. So that the dentist, our staff, and our other patients will not be penalized by those who fail to keep scheduled appointments, (24 hour advance notification), will result in a $35.00 fee being charged. That charge which is in accordance with our dental office's broken appointment policy for all patient's, is to be paid prior to the scheduling of any new appointment. The patient is responsible for payment of the charge.

Patient Signature:____________________________________ **Date:**__________________

Parent/Guardian if patient is a minor

Dental History:

Reason for Today's visit:_______________________________ Date of last dental care:____________________

Former Dentist:___________________________________ Date of last dental X-Rays:_____________________

Have you had any head, neck or jaw injuries? ☐Yes ☐No Do you feel pain to any of your teeth? ☐Yes ☐No

Check (√) if you have had problems with any of the following:

☐ Bad Breath	☐ Food collection between teeth	☐ Periodontal treatment	☐ Sensitivity to sweets
☐ Bleeding gums	☐ Grinding teeth/Clenching	☐ Sensitivity to cold	☐ Sensitivity when biting
☐ Clicking /Popping jaw	☐ Loose teeth or broken fillings	☐ Cold sores/Growths in mouth	☐ Sensitivity to hot

Medical History:

Physicians Name:____ Date of last visit:____________________

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Apidex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine)? ☐ Yes ☐No

Have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing bisphosphonates? ☐Yes ☐No

Have you had any serious illnesses or operations? ☐ Yes ☐No If yes, describe:________________________________

Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, give approximate dates:_____________________________

(Women) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control? Yes ☐No ☐

Check (√) if you have had problems with any of the following:

☐ Anemia	☐ Cortisone Treatments	☐ Hepatitis/Jaundice	☐ Respiratory Problems
☐ Arthritis	☐ Cough, Persistent	☐ High Blood Pressure	☐ Rheumatic Fever
☐ Artificial Heart Valves	☐ Diabetes	☐ History of Smoking	☐ Shortness of breath
☐ Artificial Joints	☐ Epilepsy/Seizures	☐ HIV / AIDS	☐ Skin Rash
☐ Asthma	☐ Fainting	☐ Jaw Pain	☐ Stroke
☐ Back Problems	☐ Glaucoma	☐ Joint Replacement / Implant	☐ Swelling feet/ankles
☐ Blood Disease	☐ Hay Fever/ Allergies	☐ Kidney Disease	☐ Thyroid Problems
☐ Cancer	☐ Headaches	☐ Liver Disease	☐ Tobacco Habit
☐ Chemotherapy / Radiation	☐ Heart Murmur	☐ Mitral Valve Prolapse	☐ Tuberculosis
☐ Chest Pains	☐ Heart Problems	☐ Pacemaker	☐ Ulcer
☐ Circulatory Problems	☐ Hemophilia	☐ Psychiatric Treatment	☐ Venereal Disease

Medications	Allergies / Allergies to medications
________________________________	________________________________
________________________________	________________________________

Authorization

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize Dr. Williams to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to Dr. Williams or dental group insurance benefits otherwise payable to me. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature: ____ **Date:** ____________________