Welcome to Our Practice! This confidential information will help us prepare for your visit.

NAME _____
Mr. Mrs. Ms. Rev. Dr.

I prefer to be addressed as _____

Birthdate ___/___/___ SS# _____-_____-_____

Address _____

_____ Zip _____

E-mail Address _____

❑Single ❑Married ❑Divorced ❑Widowed ❑Separated

Home # _____ Cell # _____

Work # _____ Ext. _____

Where and when is best to reach you? _____

Employer _____

Address _____

City _____ Zip_____

Occupation _____ There for ___ yrs

Who referred you to our office? _____

Other family members seen by us _____

Your last dental visit _____

Seen by Dr. _____ for _____

Spouse's Name _____

Birthdate ___/___/___ Work # _____

Employer _____

Address _____

Occupation _____ There for ____yrs

Account Information
Name on Account ❑Self ❑Spouse ❑Other

Preferred Payment Arrangements (please check one)

- ❑ Cash or personal check at time of treatment
- ❑ Credit Card at time of treatment
- ❑ I wish to apply for credit with a lending institution through your office. I authorize a credit history report.

Why have you made this dental appointment?

_____

Why have you decided to leave your previous dental office?

_____

Please check one box in each section

- ❑ My mouth is very comfortable.
- ❑ My mouth is moderately comfortable.
- ❑ My mouth is uncomfortable.
- ❑ I think the appearance of my smile is excellent.
- ❑ I am satisfied with the appearance of my smile.
- ❑ I would like to change my smile.
- ❑ I am unconcerned about the appearance.
- ❑ I will do whatever I must to keep my teeth.
- ❑ I want to keep my teeth but only within a certain budget of time and money.
- ❑ I am indifferent about keeping my teeth.
- ❑ I have always done what was recommended to me.
- ❑ I have not done what was recommended to me.
- ❑ I have not had dentistry recommended to me.
- ❑ I put dental care high on my list for myself
- ❑ I put dental care low on my list.
- ❑ I have never considered where I put dental care.
- ❑ I think my present state of dental health is excellent
- ❑ I think my present state of dental health is good
- ❑ I think my present state of dental health is poor

Obstacles I see to excellent dental health for myself...
If you select more than one of the following please number them in order of significance with #1 being that which is most significant for you at this time.

_____ I see no obstacles

_____ Time away from work or other obligations

_____ Fear of pain, surgery, or injections

_____ Fear because of past dental experiences

_____ The cost of treatment

_____ Other _____

PLEASE TURN OVER AND COMPLETE THE ADDITIONAL INFORMATION ON BACK .....

Are you under the care of a physician? ❑ No ❑ Yes

Physician Name _____

Office location _____

Office telephone _____

List all medications you take (prescription and over counter)

_____
_____
_____
_____
_____
_____
_____

Do you have or have you ever had any of the following:

Y	N	
❑	❑	High / Low Blood Pressure _____
❑	❑	Heart Attack _____
❑	❑	Infective Endocarditis _____
❑	❑	Mitral Valve Prolapse _____
❑	❑	Heart Surgery _____
❑	❑	Heart Murmur _____
❑	❑	Pacemaker _____
❑	❑	Rheumatic fever _____
❑	❑	Artificial Valve _____
❑	❑	Hemophilia / Bleeding _____
❑	❑	Stroke _____
❑	❑	Anemia _____
❑	❑	Blood Transfusion _____
❑	❑	Cancer _____
❑	❑	Chemotherapy _____
❑	❑	Radiation Treatment _____
❑	❑	HIV / AIDS _____
❑	❑	Venereal Disease _____
❑	❑	Shingles _____
❑	❑	Scarlet Fever _____
❑	❑	Fever Blisters _____
❑	❑	Cold Sores _____
❑	❑	Arthritis _____
❑	❑	Artificial Joint _____
❑	❑	Hepatitis _____
❑	❑	Kidney Problems _____
❑	❑	Diabetes _____
❑	❑	Ulcers _____
❑	❑	Colitis _____
❑	❑	Tuberculosis _____
❑	❑	Emphysema _____
❑	❑	Asthma _____
❑	❑	Difficulty Breathing _____
❑	❑	Epilepsy / Seizures _____
❑	❑	Psychiatric Problems _____
❑	❑	Fainting _____
❑	❑	Glaucoma _____
❑	❑	Sinus Trouble _____
❑	❑	Drug/Alcohol Dependence _____
❑	❑	Hospitalized _____
❑	❑	Severe or Frequent Headaches _____
❑	❑	Latex Allergy
❑	❑	Drug Allergies _____
❑	❑	Other Allergies _____
❑	❑	Do you exercise regularly

If YES what do you enjoy doing? _____

What do you enjoy doing in your spare time? _____

For Women

Are you taking birth control pills ❑No ❑Yes
Are you pregnant ❑No ❑Yes
Are you nursing ❑No ❑Yes

The information present on these pages is true to the best of my knowledge. The undersigned authorizes the doctor to take X-rays, study models, photographs, or other diagnostic materials deemed appropriate by the doctor in order to make a thorough diagnosis of the condition of my dental health. I authorize the doctor to perform/deliver any and all forms of treatment, medication and therapy that may be indicated in connection with the services required for my dental health. I understand that the doctor will discuss treatment before it is initiated. I further authorize and consent that the doctor may choose and employ any assistance as deemed fit.

I understand that the responsibility for payment for professional services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless written financial arrangements have been made and signed by me. In the event of default I promise to pay interest on the indebtedness, together with any collection costs and attorney fees as may be required to effect collection.

SIGNED _____ **DATE** _____

Thank you for filling this form out completely. If you have questions regarding this form or any aspect of our dental practice please call.

Jared Williams D.D.S. **(480) 962-1561**

Dental Insurance Information

DENTAL INSURANCE ❑YES ❑NO

Name of carrier: _____

Person responsible for insurance: _____

Relationship: _____

Social Security # _____ DOB _____

As a service to our valued patients WE SUBMIT CLAIMS TO YOUR INSURANCE COMPANY ON YOUR BEHALF.