CLIFFORD WILLIAMS DMD
AQUAINTANCE FORM

DATE: _____

NAME: _____ HOME PHONE (____)_____

ADDRESS: _____ BUS PHONE (____)_____

_____

_____ CELL PHONE (____)_____

DATE OF BIRTH: _____ E- MAIL ADDRESS: _____

SOCIAL SECURITY #_____ SEX : MALE / FEMALE

MARITIAL STATUS: _____

RESPONSIBLE PARTY IF DIFFERENT THAN PATIENT_____

ADDRESS: _____

SUBSCRIBER NAME: _____

SUBSCRIBER SOCIAL SECURITY NUMBER AND ID# : _____

SUBSCRIBER DATE OF BIRTH: _____

EMPLOYER'S NAME: _____

DENTAL PLAN NAME: _____

DENTAL PLAN ADDRESS:_____

_____

INSURANCE PHONE (____)_____

GROUP # _____

PAYOR# _____

IN CASE OF AN EMERGENCY NOTIFY: _____

PHONE # _____

PHYSICIAN'S NAME: _____

PHONE # _____

REFERRED BY: _____

PATIENT CONSENT

I hereby authorize Dr. Clifford Williams and his associates at One Rockefeller Plaza, Suite 2229, New York to perform upon the above named patient or myself the needed and/or wanted dental procedures.

Dr. Williams has explained and answered any questions this / the procedure(s) and I fully understand this / the procedure(s) and any complications that may arise.

_____

Patient or Guardian signature

REVIEWED BY: _____ DATE: _____ DATE: _____ DATE: _____

PATIENT'S NAME: _____

MEDICAL & DENTAL HISTORY FORM

PLEASE CIRCLE YES or NO

1. ARE YOU CURRENTLY UNDER THE CARE OF A PHYSICIAN..... YES NO
2. ARE YOU ALLERGIC TO ANY MEDICATION?..... YES NO
   NAME OF MEDICATION_____
3. HAVE YOU EVER HAD A REACTION FROM ANESTHETICS?..... YES NO
4. HAVE YOU BEEN HOSPITALIZED WITHIN THE PAST 5 YEARS?..... YES NO
   IF YES, WHAT FOR_____
5. HAS THERE BEEN ANY CHANGES IN YOUR HEALTH WITHIN THE LAST YEAR?..... YES NO
6. ARE YOU TAKING ANY MEDICATION EITHER PRESCRIBED OR NON PRESCRIBED..... YES NO
   LIST MEDICATION_____
7. DO YOU HAVE ANY OF THE FOLLOWING DISEASES OR PROBLEMS?
   (If yes please circle which one is applicable.)
   a. Damaged heart valves or artificial heart valves, including heart murmur or rheumatic heart disease..... YES NO
   b. Cardiovascular disease (heart trouble, heart attack, angina, coronary insufficiency, coronary occlusion high blood pressure, arteriosclerosis, strokes) If yes please circle which one is applicable..... YES NO
   c. Low blood pressure..... YES NO
   d. Allergies..... YES NO
      1. Are you allergic to latex?
         i. Are you allergic to or unable to eat bananas, avocados, chestnuts, kiwi, hazelnut, potatoes, tomatoes?..... YES NO
         ii. Do you have a history of surgery, especially, several repeated procedures in childhood?..... YES NO
         iii. Do you have Spina Bifida?..... YES NO
         iv. Repeated urinary catherization?..... YES NO
         v. Can you blow up balloons?..... YES NO
         vi. Do you work in the health profession?..... YES NO
   e. Sinus Trouble..... YES NO
   f. Asthma or hay fever..... YES NO
   g. Fainting spells or seizures..... YES NO
   h. Persistent diarrhea or recent weight lose..... YES NO
   i. Diabetes..... YES NO
   j. Hepatitis, jaundice or liver disease..... YES NO
   k. AIDS or HIV infection..... YES NO
   l. Sexually transmitted disease..... YES NO
   m. Thyroid problems..... YES NO
   n Respiratory problems, emphysema, bronchitis, etc..... YES NO
   o. Arthritis or swollen joints..... YES NO
   p. Stomach ulcers or hyperacidity..... YES NO
   q. Kidney troubles..... YES NO
   r. Tuberculosis..... YES NO
      1. Do you have a heavy, persistent cough of 2-3 weeks duration, particularly one that brings up sputum or blood..... YES NO
      2. Do you wake up multiple times at night to change your clothes and bedding because they are unusually saturated with perspiration?..... YES NO
   s. Persistent swollen glands in neck..... YES NO
   t. Epilepsy or other neurological disease..... YES NO
   u. Problems with mental health..... YES NO
   v. Cancer..... YES NO
   w. Problems with immune system..... YES NO
8. HAVE YOU HAD ABNORMAL BLEEDING?..... YES NO
   a. Have you ever had a blood transfusion?..... YES NO
9. DO YOU HAVE ANY BLOOD DISORDER SUCH AS ANEMIA?..... YES NO
10. HAVE YOU EVER HAD ANY TREATMENT FOR A TUMOR OR GROWTH?..... YES NO

WOMEN:

ARE YOU PREGNANT?..... YES NO
ARE YOU NURSING?..... YES NO
ARE YOU TAKING BIRTH CONTROL PILLS?..... YES NO

DENTAL HISTORY

1.WHEN WAS YOUR LAST EXAMINATION AND PROPHYLAXIS TREATMENT _____
MONTH/ YEAR

2.DO YOU WEAR A REMOVABLE APPLIANCE..... YES NO
3.ANY COMPLICATIONS DURING OR FOLLOWING DENTAL TREATMENT?..... YES NO
4. DO YOUR GUMS BLEED WHEN YOU BRUSH?..... YES NO
5. ARE ANY OF YOUR TEETH SENSITIVE TO HEAT, COLD OR PRESSURE?..... YES NO
6. DO YOU CLENCH OR GRIND YOUR TEETH?..... YES NO
7. ARE YOU UNHAPPY WITH THE APPEARANCE OF YOUR TEETH?..... YES NO
8. WOULD YOU LIKE YOUR SMILE TO LOOK BETTER OR DIFFERENT?..... YES NO
9. WOULD YOU BE INTERESTED IN PARTICIPATING IN DR. WILLIAMS' LECTURES, ARTICLES, AND/OR TELEVISION APPEARANCES?..... YES NO

CHIEF DENTAL COMPLAINTS OR CONCERNS OR ANY ADDITIONAL INFORMATION:

_____

_____