RON T. WILLIAMSON DDS AND ASSOCIATES PLC
1964 W. 11 MILE ROAD • SUITE 4 • BERKLEY, MICHIGAN 48072
248.399.4455

MISSION STATEMENT:
Our office is committed to providing the highest quality dental care to all of our patients. We do this with a gentle, comfortable and accepting atmosphere. Dr. Williamson's team consists of dental assistants and hygienists who will be ever so vigilant to carry out your treatment with care and dignity. The administrative team takes a personal interest in all aspects of the office and understands the needs of each patient.

PATIENT PERSONAL INFORMATION

Complete Name: _____ Email Address: _____

Social Security #: _____ Sex: M F Birth Date: _____ Weight: _____

Residence Address: _____

City: _____ State: _____ Zip: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Res. Phone: _____ Cell Phone: _____ Bus. Phone: _____

Best phone # to be reached at: _____

Marital Status: ☐ Single ☐ Married ☐ Partnered ☐ Divorced ☐ Widowed

Occupation: _____

Place of Employment: _____

Business Address: _____

City: _____ State: _____ Zip: _____

SPOUSE INFORMATION

Name: _____ Birth Date: _____

Social Security #: _____ Occupation: _____

Place of Employment: _____

Business Address: _____

City: _____ State: _____ Zip: _____

Bus. Phone: _____

PERSON TO CONTACT IN CASE OF EMERGENCY (Outside of Immediate Family Household)

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

Whom may we THANK for referring you to this office? _____

ACCOUNT & INSURANCE INFORMATION

Who is responsible for your account? _____

Name: _____

Relationship: _____ Social Security #: _____

Address: _____

City: _____ State: _____ Zip: _____

Bus. Phone: _____

INSURANCE INFORMATION

- MINOR CHILDREN - MAY NEED TO COMPLETE BOTH BLOCKS FOR PATIENT INFORMATION
- ADULTS - COMPLETE PRIMARY INSURED
- DUAL COVERAGE? ALSO COMPLETE SECONDARY INSURED

PRIMARY INSURED

Last	First	MI

Street	City	State	Zip

Home#	Work#	Fax#	Email

Birthdate (Mo/Day/Year)	Relationship to Patient

Employer	Dental Insurance Co.

SS#	Subscriber#	Group#

SECONDARY INSURED

Last	First	MI

Street	City	State	Zip

Home#	Work#	Fax#	Email

Birthdate (Mo/Day/Year)	Relationship to Patient

Employer	Dental Insurance Co.

SS#	Subscriber#	Group#

ARE YOU ALLERGIC TO OR HAVE KNOWLEDGE OF BEING SENSITIVE TO:

- ☐ Codeine or Narcotics
- ☐ Sleeping Pills
- ☐ Novocaine or Local Anesthetics
- ☐ Aspirin
- ☐ Darvon
- ☐ Penicillin
- ☐ Tetracycline
- ☐ Sulpha
- ☐ Iodine
- ☐ Metals
- ☐ Latex
- ☐ Others

PHYSICIAN'S INFORMATION

Physician's Name: _____

Date of Last Visit: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

What pills or medications are you taking now? _____

Over the Counter: _____

_____

_____

Prescriptions: *(Including birth control, tranquilizers, nitroglycerin, cortisone, blood thinners, insulin, antihistamines, digitalis, diuretics, dilantin)* _____

_____

_____

Herbals and Supplements: _____

_____

_____

_____

Please circle Y(yes) if you HAVE or N(no) if you HAVE NOT been treated for the following conditions

1. Y N Heart Murmurs
2. Y N Rheumatic Fever/Rheumatic Heart Disease
3. Y N Congenital Heart Disease
4. Y N Cardiovascular Stent - When_____
5. Y N Artificial Joint Replacement
6. Y N Artificial Heart Valve
7. Y N High Blood Pressure
8. Y N Angina
9. Y N Heart Attack - When_____
10. Y N Arrhythmia - What Type _____
11. Y N Congestive Heart Failure
12. Y N Emphysema or Lung Disease
13. Y N Asthma
14. Y N Tuberculosis
15. Y N Kidney Disease
16. Y N Hemodialysis
17. Y N Hepatitis
18. Y N Cirrhosis
19. Y N Alcohol Abuse
20. Y N Ulcers
21. Y N HIV/AIDS
22. Y N Arthritis
23. Y N Stroke
24. Y N Epilepsy
25. Y N Diabetes
26. Y N Hypo/Hyper Thyroidism
27. Y N Prolonged/Excessive Bleeding
28. Y N Hemophilia
29. Y N Liver Disease
30. Y N Anticoagulation therapy-Blood Thinners
31. Y N Anemia
32. Y N Sickle Cell Anemia
33. Y N Cancer
34. Y N Radiation Therapy
35. Y N Chemotherapy
36. Y N Behavioral/Psychiatric Disorders
37. Y N Latex Allergy
38. Y N Are you pregnant
39. Y N Any Blood Disorders
40. Y N Shortness of Breath
41. Y N Sinus Problems
42. Y N Jaundice
43. Y N Hives, Skin Rashes
44. Y N Persistent Cough or Coughing of Blood
45. Y N Headaches, Migraines
46. Y N Glaucoma or Eye Problems
47. Y N Swollen Ankles
48. Y N Gout
49. Y N Polio
50. Y N Frequent Colds
51. Y N Nose Bleeds
52. Y N Frequent Sores in Mouth or Throat
53. Y N Vomiting
54. Y N Syphilis
55. Y N Bisphosphonates: By I.V. or Pill
(for Osteoporosis or During Chemotherapy)
56. Y N PHEN/FEN
57. Y N Have you ever been hospitalized for any of the conditions listed?

Describe:_____

_____

_____