# Jaw Joint Science Institute

**Dr. Edward D. Williams**

7700, Crittenden Street, Market Square at

Chestnut Hill Philadelphia, PA 19118

215-242-3141

PLEASE TURN OFF ALL CELLPHONES BEFORE ENTERING TREATMENT AREA!
NOTE! THERE IS A $34.00 FEE FOR BROKEN OR CANCELLED APPOINTMENTS WITHOUT 24 HR. NOTICE!

## About You

Today's Date: _____

Social Security: _____

Name: _____

Home Address: _____

_____ _____ _____ _____
Apt. City State Zip Code

## Mailing Address, If Different:

Address: _____

_____ _____ _____
City State Zip Code

## Your Employer:

Occupation: _____

How Long held _____ years _____ Months

Birthday _____ (mm/dd/yy)

Gender : Male ◯ Female ◯

Marital Status : Single ◯ Married ◯ Divorced ◯ Widowed ◯

**Do you or any family member play sports or participate in recreational exercise?**

Yes ◯ No ◯

_____ _____ _____
Sport Position Years Played

**Bring all current medications with you at each dental visit.**

## Telephone

Home: _____ Work: _____

Cell/Beeper: _____

Email _____

When is the best time to reach you? _____

Where? _____ Spouses work phone# _____

**In event of an emergency, is there someone who lives near you that we could contact?**

Name: _____ Relationship _____

Work# _____ Home# _____

## List all Dental Benefit Plans

**Primary Dental Plan**

Subscribers' Name _____

Insurance Carriers _____

Group#: _____

Identification#: _____

Carrier Phone# _____

Carrier Address: _____

_____ _____ _____
City State Zip Code

**Secondary Dental Plan**

Subscribers' Name _____

Insurance Carriers _____

Group#: _____

Identification#: _____

Carrier Phone# _____

Carrier Address: _____

_____ _____ _____
City State Zip Code

**Primary Medical Plan**

Subscribers' Name _____

Insurance Carriers _____

Group#: _____

Identification#: _____

Carrier Phone# _____

Carrier Address: _____

_____ _____ _____
City State Zip Code

## This coverage

**I authorize the release of any dental or medical information to process my claim**

**Signature:** _____

Date _____

**I authorize payment directly to Dr. Edward D. Williams**

**Signature:** _____

Date _____

We would like to take this opportunity to welcome and thank you for joining our dental family. We appreciate your confidence in us and we will do everything possible to provide you with the finest dental care in a painless environment. **WE CATER TO DENTAL COWARDS!**

Referred by: Friend ◯ Relative ◯ Lawyer ◯ Other ◯

Name _____

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

# Medical History

## *Personal Health History*

**Personal Physician Name:**

_____

**Address:** _____

_____

**Are you currently being treated by your physician**

Reason_____

**Phone#**_____ **Date last Visit**_____

**List All Medications or Drugs You Are Currently Taking**

Meds_____ Dosage_____
Meds_____ Dosage_____
Meds_____ Dosage_____
Meds_____ Dosage_____

**Have you had any serious medical problems in the last 5 years?** ◯ *Yes or* ◯ *No if yes please explain:*

_____

**Have you ever been hospitalized or undergone surgery?**
◯ *Yes or* ◯ *No If yes, please explain and give dates:*

_____

**Do you smoke or use tobacco in any other form?**
◯ *Yes or* ◯ *No*

_____

**Are you pregnant?** ◯ *Yes or* ◯ *No*

**Have you ever been or need to be pre-medicated before dental treatment?** ◯ *Yes or* ◯ *No*

**Have you ever been in an auto accident?** ◯ *Yes or* ◯ *No*

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

◯ *Yes or* ◯ *No* Heart attack/stroke
◯ *Yes or* ◯ *No* Heart Murmur/Rheumatic Fever
◯ *Yes or* ◯ *No* Heart Surgery/Pacemaker
◯ *Yes or* ◯ *No* Chronic Hepatitis
◯ *Yes or* ◯ *No* Anemia
◯ *Yes or* ◯ *No* High/Low Blood Pressure
◯ *Yes or* ◯ *No* Severe Headaches
◯ *Yes or* ◯ *No* Epilepsy/Seizures/Fainting Spells
◯ *Yes or* ◯ *No* Drug/Alcohol Abuse
◯ *Yes or* ◯ *No* Hemophilia/Abnormal Bleeding
◯ *Yes or* ◯ *No* Cancer/Chemotherapy
◯ *Yes or* ◯ *No* HIV or/ & AIDS
◯ *Yes or* ◯ *No* Shingles
◯ *Yes or* ◯ *No* Kidney Problems
◯ *Yes or* ◯ *No* Sinus Problems
◯ *Yes or* ◯ *No* Hay Fever
◯ *Yes or* ◯ *No* Psychiatric Problems
◯ *Yes or* ◯ *No* Diabetes
◯ *Yes or* ◯ *No* Tuberculosis (TB)
◯ *Yes or* ◯ *No* Sickle Cell Disease
◯ *Yes or* ◯ *No* Asthmatic
◯ *Yes or* ◯ *No* Arthritis

**Are you allergic to any of the following drugs?**

◯ *Yes or* ◯ *No* Penicillin
◯ *Yes or* ◯ *No* Erythromycin
◯ *Yes or* ◯ *No* Dental Anesthetics
◯ *Yes or* ◯ *No* Aspirin
◯ *Yes or* ◯ *No* Tetracycline
◯ *Yes or* ◯ *No* Codeine

**Are you allergic to any other drugs or foods?** ◯ *Yes or* ◯ *No*

*If yes, please list*: _____

## Dental History

**Are you currently in pain?** ◯ *Yes or* ◯ *No*

**Are you under any unusual stress at home or work?**
◯ *Yes or* ◯ *No*

**Do you experience stress or anxiety in the dental office?**
◯ *Yes or* ◯ *No*

**The approximate date of your last dental visit:** _____

**Have you ever-experienced TMJ, jaw joint, recurring Headaches or facial pains?**
◯ *Yes or* ◯ *No*

**Do you grind your teeth?** ◯ *Yes or* ◯ *No*

**Your current dental health is:** ◯ *Good* ◯ *Fair* ◯ *Poor*

**Do your gums ever bleed?** ◯ *Yes or* ◯ *No*

**Are you interested in Dental implants?** ◯ *Yes or* ◯ *No*

**Would you like to have whiter teeth?** ◯ *Yes or* ◯ *No*

I understand that the information that i have given today is correct to the best of my knowledge. I also understand that the information will be held in strictest confidence and it is my responsibility to inform the office of any changes in my medical status.

**Signature**_____

**Date**_____

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

***Thank you for filling out this form completely. It will enable us to help you more effectively. If you have any questions at any time please ask us. We are happy to help. Because We Care!***