



**THOMAS H. WILLIAMS, D.M.D., P.C.**  
**GENERAL, COSMETIC, & IMPLANT DENTISTRY**  
 5740 CARMICHAEL ROAD, MONTGOMERY, AL 36117  
 PHONE (334) 277-9570 TOLL FREE (866) 277-9570 FAX (334) 277-0152  
 EMAIL OFFICE @ THWILLIAMS.COM WEBSITE [WWW.THWILLIAMS.COM](http://WWW.THWILLIAMS.COM)

**New Patients:**

Please return this completed Patient Information Forms along with a copy of both sides of your dental and medical insurance cards ASAP (at least 2 days before your appointment) so that we may be prepared for your visit. Fax: 334-277-0152, Email: [office@thwilliams.com](mailto:office@thwilliams.com), or Return mail

**Patient Information**

Patient Name:      Date:   
Last Name, First MI (Preferred Name) mm/dd/yyyy

Male  female Family Status:  single  married  widowed  divorced  separated  child

Social Security #  Birth Date  Age  Driver License #

Phone (Home):  (Work):  Ext:  Best Time to Call:

Cell Phone:  Fax:  Email:

Home Address:      
Street Apartment #  
    
City State Zip Code

Whom may we thank for referring you to our practice?   
 Another Patient  Friend  Relative  Dental Office  TV  Yellow Pages  Internet  Other

**Health Information**

**Have you ever had any of the following? Please check those that apply:**

- AIDS/HIV
- Allergies
- Alcoholism
- Acid Reflux Disease
- Anemia
- Arthritis
- Artificial Joints
- Asthma
- Blood Disease
- Chemotherapy
- Cancer
- Diabetes
  - diet controlled
  - medication Rx
  - take Insulin
- Dizziness
- Drug Addictions
- Epilepsy
- Excessive Bleeding
- Fear of Dentists
- Frequent Headaches

- Fosomax, Bovina, etc
- Glaucoma
- Growths, Tumors, etc
- Head/Face Injuries
- Heart Disease/Attack
- Heart Valve Problem
- Hepatitis A, B, C
- Hospitalizations
- High Blood Pressure
- Jaundice
- Kidney Disease
- Liver Disease
- Major Surgery
- Mental Disorders
- Mouth Injuries
- Nervous Disorders
- Osteoporosis
- Pacemaker
- Psychiatric Problems
- Pregnant Now

- Due date:
- Respiratory Problems
  - Rheumatic Fever
  - Sinus Problems
  - Smoker
  - Stomach Problems
  - Recent Steroid Rx's
  - Stroke
  - TMJ jaw problems
  - Tuberculosis
  - Thyroid Problems
  - Take Aspirin Daily
  - Take Blood Thinners
  - Venereal Disease
  - Codeine Allergy
  - Penicillin Allergy
  - Anesthetic Allergy

Other Medications Allergies Please List Below:

List Daily Rx Medications:

- Have you been admitted to a hospital or needed emergency care during the past two years?  Yes  No

If yes, please explain:

- Are you now under the care of a physician?  Yes  No

If yes, please explain:

- Name of Physician:

City:

State:

- Do you have any health problems that need further clarification?  Yes  No

If yes, please explain:

### Dental Information

Reason for today's visit:  Exam  Emergency  Consultation

Are you in pain?  No  Yes

How long?

#### Please check those that apply:

<input type="checkbox"/> Discomfort, clicking, or popping in jaw	<input type="checkbox"/> Ringing in Ears	<input type="checkbox"/> Difficulty Chewing
<input type="checkbox"/> Red, swollen, bleeding gums	<input type="checkbox"/> Broken/Chipped Tooth	<input type="checkbox"/> Embarrassed to Smile
<input type="checkbox"/> Sensitive tooth, teeth, gums	<input type="checkbox"/> Stained Teeth	<input type="checkbox"/> Would like Whiter teeth
<input type="checkbox"/> Blisters/Sores in or around the mouth	<input type="checkbox"/> Locking Jaw	<input type="checkbox"/> Pain upon chewing
<input type="checkbox"/> Lost/Broken Fillings	<input type="checkbox"/> Bad Breath	<input type="checkbox"/> Use Smokeless tobacco
<input type="checkbox"/> Teeth grinding		<input type="checkbox"/> Smoke

My Concerns about Dental Treatment are:  Fear  Finances  Time

Date of Last Dental Visit:

Reason for last dental visit:

Date of Last Complete Mouth Dental X-rays:

Previous Dentist Name:

City:

State:

Have you ever had any complications following dental treatment?  Yes  No

If yes, please explain:

How would you rate your dental health? Circle (worst) 1 2 3 4 5 6 7 8 9 10 (best)

How can we help you with your dental needs?

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Signature of patient, parent or guardian

Date

### Spouse or Responsible Party Information

The following is for:  the patient's spouse  the person responsible for payment

Name:

Male  Female  Married  Single  Divorced  Widowed

Social Security #:  Birth Date:

Phone Home:  Work:  Ext.:  Best Time to Call:

Address:

Street  Apartment #  
 City  State  Zip Code

### Employment Information

The following is for:  the patient  the person responsible for payment

Employer Name:  Occupation:

How long employed:  Months/Years Work hours:

Address:

Street  Apartment #  
 City,  State  Zip Code  Phone

### Dental Insurance Information

#### Primary Dental Insurance

Name of Insured:  Is the Insured a patient?:  Yes  No

Last  First  MI  
Insured's Birth Date:  ID #:  Group #:

Insured's Address:      
Street City State Zip Code

Insured's Employer Name:

Address:      
Street City State Zip Code

Patient's relationship to insured:  Self  Spouse  Child  Other

Insurance Plan Name:

Address:

#### Secondary Dental Insurance

Name of Insured:  Is the Insured a patient?:  Yes  No

Last  First  MI  
Insured's Birth Date:  ID #:  Group #:

Insured's Address:      
Street City State Zip Code

Insured's Employer Name:



### Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed. Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of two months from the date of the patient examination. In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form. I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I understand that dentistry is not an exact science and no guarantees or assurance of the outcome or results of treatment or surgery can be made or implied. I understand that excessive smoking, alcohol, or sugar; and poor oral hygiene and not following my doctor's home care instructions may effect my healing and may limit the success of my dental treatment. I also give my permission for any photographs, images, x-rays, or models to be taken and used by Drs. Williams for the advancement of dentistry. I understand that I am responsible for all costs and payment for professional services rendered.

I understand that if for any reasons my account becomes delinquent, I agree to pay all late charges, interest, collections costs, and reasonable legal fees. I hereby authorize any release of any information, including the diagnosis and records of treatment to my insurance company, or other doctor's offices as requested. I have been given a copy of this office's Hipaa privacy policies. After an initial examination, a written estimate for the recommended dental treatment will be given, and financial arrangements along with risks, benefits and alternative treatments will be discussed at that time. I understand that most financial payment plans require a routine credit assessment and do hereby give my permission in order to help make my dentistry more affordable.

I request and authorize Drs. Williams and/or staff to provide dental services and fully understand that during, and following the contemplated procedure, surgery, or treatment, conditions may become apparent which warrant, in the judgment of the doctor, additional or alternative treatment pertinent to the success of comprehensive treatment. I agree the type of anesthesia and/or sedation that Drs. Williams chooses, and agree not to operate a motor vehicle or hazardous device for at least 12 hours or more until fully recovered from the effects of sedation or the anesthesia or drugs given for my care.

I have read the above conditions of treatment and payment and agree to their content.

Signature of Patient, Parent, Guardian, or Responsible Party

date

