THOMAS H. WILLIAMS, D.M.D., P.C.
RESTORATIVE, COSMETIC, & IMPLANT DENTISTRY
5740 CARMICHAEL ROAD, MONTGOMERY, AL 36117
PHONE (334) 277-9570 FAX (334) 277-0152
EMAIL: OFFICE@ THWILLIAMS.COM WEBSITE: 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, or Return mail

Patient Information

Date: _ _/_ /_ _____

Patient Name: __ ( )
Last First Middle Preferred Name

☐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: _☐am ☐pm
Cell Phone: ( )-_ - Fax: ( )- -_ Email: @ _

Are you using Social Media? ☐yes ☐ no Facebook ☐ Twitter ☐ Instagram ☐ Other☐

Home Street Address: Apartment #:

City: State: _ Zip Code: _

Person to contact in case of an emergency: Name:

Phone: ( )_ Relationship to you:

Whom may we thank for referring you to our practice? Name: _

☐Another Patient ☐Friend ☐Relative ☐Dental Office ☐TV ☐Yellow Pages ☐Internet ☐Other

Please explain: _____

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ parent or legal guardian ☐ the person responsible for payment

Last Name: __ First Name: Middle: _

☐ Male ☐ Female ☐ Married ☐ Single ☐ Divorced ☐Widowed

Social Security # _ _-_ _- Birth Date: / /

Phone Home: ( )- -_ Work: ( )- -_ Ext.: Best Time to Call:

Employment Information

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

Employer Name: Occupation: _____

How long employed: _____[__] Months/ [___] Years Work hours: _____

Street Address: _____City: _____State: _____ Zip Code:

Health Information

List Daily Rx Medications / Prescriptions

Medication or Prescription	Reason for the Medication or Prescription
1.	1.
2.	2.
3.	3.
4.	4.
5.	5.
6.	6.
7.	7.
8.	8.
9.	9.
10	10.
11.	11.
12.	12.

MEDICAL HISTORY

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, Boniva, etc.
- ☐ Glaucoma
- ☐ Growths, Tumors,
- ☐ 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
- ☐ Snoring/Sleep Apnea

Allergies Please List Below:

- 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 Health Information

Reason for today's visit: ☐Exam ☐Emergency ☐Consultation
Are you experiencing dental pain today? ☐No ☐Yes How long have you been in this pain?

Please check those that apply:

☐Discomfort, clicking, or popping in jaw ☐Red, swollen, bleeding gums ☐Sensitive tooth, teeth, gums ☐Blisters/Sores in or around the mouth ☐Lost/Broken Fillings ☐Teeth grinding	☐Ringing in Ears ☐Broken/Chipped Tooth ☐Stained Teeth ☐Locking Jaw ☐Bad Breath	☐Difficulty Chewing ☐Embarrassed to Smile ☐Would like Whiter teeth ☐Pain upon chewing ☐Use Smokeless tobacco ☐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 or Panoramic Dental X-rays: _ ___/_ ____/__ ___

Date of Last Cleaning: /_ _/__

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)

Are you financially dependent on your dental insurance plan to pay for any dental work you will need? ☐ Yes ☐ NO

Are you interested in applying for a monthly payment Plan (CareCredit)? ☐ Yes ☐NO

How can we help you with your dental needs?

Explain:
_____ _____
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Dental Insurance Information

Primary Dental Insurance

Dental Insurance Company / Plan : __ _____

Effective Date: _/ _/_
Name of Insured: (as on your insurance card): __

Is the Insured a patient in our office? ☐ Yes ☐ No Insured's Birth Date: ___/ ___/_ __ ID #: _ _____
Group #: _____ SS#: _ ___-_ ___-_ _____

Insured's Employer: __ _____ City _ _____State: _____

Patient's relationship to insured: ☐Self ☐ Spouse ☐ Child ☐ Other: _ _____

Secondary Dental Insurance (Note; Many Secondary Dental Plans do not pay the same as if they are Primary)

Secondary Dental Insurance Company/ Plan ___ _____

Effective Date: / / Name of Insured: (as on your insurance card): _ ____

Is the Insured a patient in our office? ☐ Yes ☐ No Insured's Birth Date: /_ __/_ __ ID #: __

Group #: _____ SS#: -__ -_

Insured's Employer: ____ City _ _____State: __

Patient's relationship to insured: ☐Self ☐ Spouse ☐ Child ☐ Other: _____

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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. As your Dentist, I want to provide you with the best care possible. There are services that I feel are necessary for the treatment of your condition and maintenance of good health that are not covered by your dental insurance benefits contract. You are expected to pay for those services in full. Let me reassure you that I will order only treatments that I feel are necessary for your dental health and care. In addition, some services may be recommended by me for cosmetic and more personalized results and reasons. If you have any questions about whether or not a particular service is covered by your dental benefits contract, someone in our office will be happy to assist you. Thank you for your understanding. 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 conditions I further agree to pay all costs and reasonable attorney fees associated with any collection efforts if law suit is 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 affect 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 Dr. Williams for the advancement of dentistry. I understand that I am responsible for all costs and payment for professional services rendered. This Contract shall be governed by the laws of the State of Alabama. Venue shall be proper in Montgomery County, Montgomery, Alabama.

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 HIPPA 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 Dr. 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 Dr. 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 / /

STAFF __ __ _____

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CANCELLATION / BROKEN APPOINTMENT POLICY

Our dental practice operates by appointment only. We reserve specific amounts of time to provide our patients with the highest quality dental care and services. Our office utilizes Demand Force; an appointment reminder text messages and emails service, to better serve our patients. We respectfully require 24-hour notice for cancellation or rescheduling of your confirmed reserved dental appointment.

A MININUM OF $50 WILL BE CHARGED TO YOUR ACCOUNT FOR LAST MINUTE CANCELLATIONS, BROKEN APPOINTMENTS, OR NO SHOWS for dental hygiene cleaning and exam visits except in the case of medical or family emergencies. If you do not show for your confirmed cleaning appointment, your hygienists will not have a patient for that hour!

BECAUSE OF LAB COSTS, SURGICAL AND IMPLANT COSTS, SET-UP COSTS, AND MAJOR AMOUNTS OF RESERVED DOCTOR TIME, WE REQUIRE PREPAYMENT OF COPAYS AND FEES AT THE TIME OF SCHEDULING. LAST MINUTE CANCELLATIONS, BROKEN APPOINTMENT, OR NO SHOWS will result in a forfeiture of those payments unless in the case of a medical or family emergency.

"Running late", or "too busy at work", or "just forgetting" are not valid excuses.

I understand and agree to the above Cancellation/Broken appointment policies.

___ _____ /_ /_

Required Patient Signature **Date**

Map to our Office

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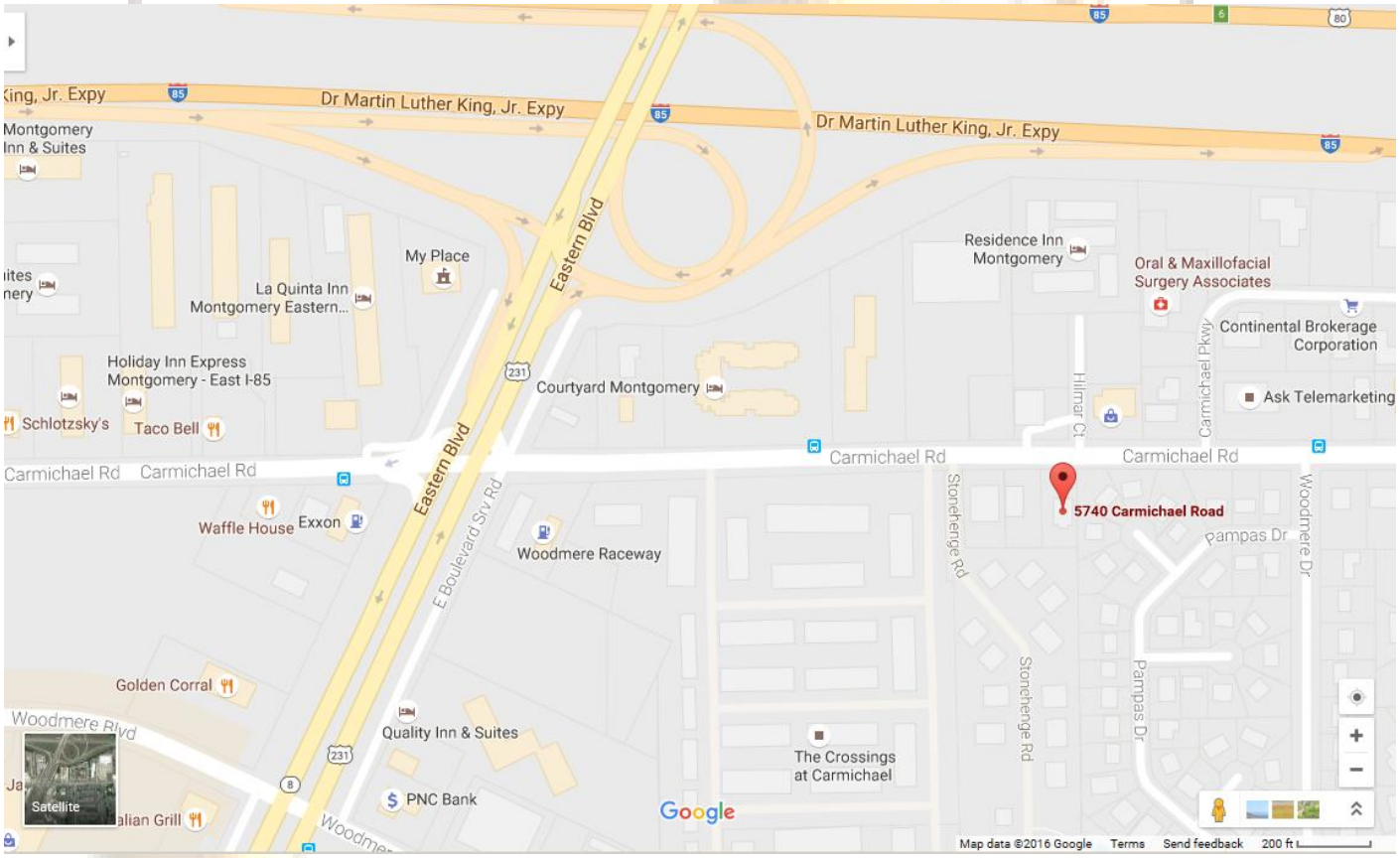

Directions: Turn at the Light, at Eastern Blvd going East on Carmichael Road, We are located across the street from the Residence Inn Hotel.