



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: ____ @ ____

Home Street Address: _____ Apartment #: _____

City: ____ State: ____ Zip Code: ____

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

Another Patient Friend Relative Dental Office TV Yellow Pages Internet Other

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.

MEDICAL HISTORY

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

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Mouth Injuries | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Fear of Dentists | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Take Aspirin Daily |
| <input type="checkbox"/> Acid Reflux Disease | <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Take Blood Thinners |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Fosomax, Boniva, etc | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Psychiatric Problems | <input type="checkbox"/> Codeine Allergy |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Growths, Tumors, etc | <input type="checkbox"/> Pregnant Now | <input type="checkbox"/> Penicillin Allergy |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Head/Face Injuries | Due date: <input type="text"/> | <input type="checkbox"/> Anesthetic Allergy |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Heart Disease/Attack | <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> Snoring/Sleep Apnea |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Heart Valve Problem | <input type="checkbox"/> Rheumatic Fever | Allergies Please List |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis A, B, C | <input type="checkbox"/> Sinus Problems | Below: |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hospitalizations | <input type="checkbox"/> Smoker | <input type="text"/> |
| <input type="checkbox"/> diet controlled | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stomach Problems | |
| <input type="checkbox"/> medication Rx | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Recent Steroid Rx's | |
| <input type="checkbox"/> take Insulin | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stroke | |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> TMJ jaw problems | |
| <input type="checkbox"/> Drug Addictions | <input type="checkbox"/> Major Surgery | | |

- 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 or have a history of head/neck 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?

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: _____

Dental Insurance Information

Primary Dental Insurance

Name of Insured: (as on your insurance card) : _____

Is the Insured a patient?: Yes No

Insured's Birth Date: _____ / _____ / _____ ID #: _____ Group #: _____ SS#: _____

Insured's Employer Name: _____

Street Address: _____ City: _____ State: _____ Zip Code: _____

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

Insurance Plan Name : _____

Secondary Dental Insurance

Name of Insured: (as on your insurance card) : _____

Is the Insured a patient?: Yes No

Insured's Birth Date: _____ / _____ / _____ ID #: _____ Group #: _____ SS#: _____

Insured's Employer Name: _____

Street Address: _____ City: _____ State: _____ Zip Code: _____

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

Insurance Plan Name : _____

Medical Insurance Information (If separate from your dental plan).

Primary Medical Insurance

Name of Insured: (as on your insurance card) : _____

Is the Insured a patient?: Yes No

Insured's Birth Date: _____ / _____ / _____ ID #: _____ Group #: _____ SS#: _____

Insured's Employer Name: _____

Street Address: _____ City: _____ State: _____ Zip Code: _____

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

Insurance Plan 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. 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 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 Dr. 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 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 that 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.

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 doctor at the next appointment without fail.

Signature of patient, parent or guardian

____/____/____
Date

Map to our Office
5740 Carmichael Rd
Montgomery, Al. 36117
phone(334)277-9570
fax(334)277-0152
email: office@thwilliams.com

