CHASE M. WILLIAMS, DDS

Patient Information

Patient Name: _____ Date: _____
Last First MI

Preferred Name: _____ ☐ Male ☐ Female | ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Cell): _____ (Work): _____ Ext: _____

Address: _____
Street City State Zip Code

Email: _____

Spouse or Responsible Party Information

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

Name: _____
☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____
Street City State Zip Code

Employment Information

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

Employer Name: _____ Occupation: _____

Address: _____
Street City State Zip Code

Referral Information

Whom may we thank for referring you to our practice? ☐ **Another patient, friend** ☐ **Another patient, relative** ☐ **Valpak**

☐ **Dental Office** ☐ **Phonebook** ☐ **Google** ☐ **Website** ☐ **Work** ☐ **Other** _____

Name of person or office referring you to our practice: _____

DENTAL HISTORY

☐ **Y** ☐ **N** Do you have a dental problem ?
Describe: _____

☐ **Y** ☐ **N** Do you receive routine dental care?
Last Visit _____
Treatment received _____
Last Cleaning _____
Last X-rays _____

☐ **Y** ☐ **N** Do you have any sores or growths in your mouth?
☐ **Y** ☐ **N** Do your gums bleed?
-How frequently do you brush? _____
-How often do you floss? _____
☐ **Y** ☐ **N** Do you have loose teeth?
☐ **Y** ☐ **N** Are you unhappy with your teeth?
What would you change? _____

☐ **Y** ☐ **N** Have you lost any teeth?
Why? _____
☐ **Y** ☐ **N** Were the missing teeth replaced?
☐ **Y** ☐ **N** If the teeth were not replaced, have you had problems with your appearance or chewing?
☐ **Y** ☐ **N** Do you have dentures?
How many Sets have you had? _____
☐ **Y** ☐ **N** Do you have clicking of the jaw?
☐ **Y** ☐ **N** Do you have frequent headaches?

☐ **Y** ☐ **N** Do you have difficulty, opening or closing?
☐ **Y** ☐ **N** Do you clench or grind you teeth? ☐ Day ☐ Night
☐ **Y** ☐ **N** Does your mouth feel dry?
☐ **Y** ☐ **N** Do you often consume sweets?
☐ Candy/Mints/Gum ☐ Soda Pop
☐ Cough Drops ☐ Coffee/Tea with sugar
☐ **Y** ☐ **N** Do you have any other questions or concerns?
Explain: _____

Snoring and Sleep Apnea

☐ **Y** ☐ **N** Do you snore loudly?
☐ **Y** ☐ **N** Do you often feel tired or fatigued after sleep?
☐ **Y** ☐ **N** Has anyone noticed that you stop breathing during sleep?
☐ **Y** ☐ **N** Have you been diagnosed with sleep apnea?
☐ Mild ☐ Moderate ☐ Severe
☐ **Y** ☐ **N** Have you attempted CPAP therapy?

Medical History

BP___/___ Pulse___

- Name:_____ Date:_____
- Your Current Physical Health Is? ☐ **Good** ☐ **Fair** ☐ **Poor**
- ☐ **YES** ☐ **NO** Are you now under the care of a physician? If yes, please explain:_____
- ☐ **YES** ☐ **NO** Have you been admitted to a hospital or needed emergency care during the past two years? If yes, please explain_____
- ☐ **YES** ☐ **NO** Are you taking any prescription or Over-The-Counter drugs? Please List Each One:_____
- ☐ **YES** ☐ **NO** Have you ever been treated for osteoporosis?
- ☐ **YES** ☐ **NO** Have you taken or are you now taking steroids?
- ☐ **YES** ☐ **NO** Do you have or have you had a problem with alcohol or drug abuse?
- ☐ **YES** ☐ **NO** Do you use or have you used tobacco products? ☐ Smoke ☐ Smokeless ☐ Quit
- **Are you allergic to any of the following?**

☐ Penicillin ☐ Latex ☐ Aspirin
☐ Tetracycline ☐ Sulfa ☐ Codeine
☐ Erythromycin ☐ Dental Anesthetics

- Please list any other drugs that you are allergic to_____
- Please check the box if you have now, or in the past, had any of the following diseases or medical problems?

☐ Heart Attack
☐ Heart trouble/surgery
☐ Stroke
☐ Chest Pain
☐ Rheumatic fever
☐ Heart Murmur
☐ Irregular Heart beat
☐ Mitral valve prolapse
☐ Pace Maker
☐ High blood pressure
☐ Low blood pressure
☐ Artificial valves
☐ Shortness of Breath
☐ Asthma/hay fever
☐ Sinus problems
☐ Diabetes
☐ Thyroid Problems
☐ Bladder Problems
☐ Cancer or Tumor
☐ Lumps/swollen glands
☐ Scalp/Skin disease
☐ Sudden weight loss
☐ Sudden weight gain
☐ HIV+/AIDS
☐ Venereal disease
☐ Syphilis/Gonorrhea
☐ Herpes
☐ Seizures
☐ Epilepsy
☐ Emphysema
☐ Tuberculosis
☐ Persistent cough
☐ Respiratory problems
☐ Anemia/blood disease
☐ Leukemia
☐ Hemophilia
Abnormal bleeding
☐ Kidney problems
☐ Jaundice/
other liver problems
☐ Fainting spells
☐ Arthritis
☐ Artificial joints
☐ Glaucoma
☐ Psychiatric
☐ Ulcers
☐ Colitis
☐ Radiation Treatment
☐ Hepatitis A, B, C
☐ Blood Transfusion
☐ Eye Problems

- Please discuss any serious medical conditions(s) that you have ever had:_____

WOMEN:

- ☐ **YES** ☐ **NO** Are you taking birth control pills?
- ☐ **YES** ☐ **NO** Are you pregnant? Week # if yes _____
- ☐ **YES** ☐ **NO** Are you Nursing?

PLEASE SIGN AND DATE BELOW

I certify that to the best of my knowledge the above information is complete and accurate. If there are changes in my health, or medicines, I will inform my doctor at the next appointment.

X_____ _____
Signature of Patient, parent or guardian **date**

CONSENT TO PROCEED

I authorize Dr. Williams and/or such associates or assistants as s/he may designate to preform those procedures as may be deemed necessary or advisable to maintain my dental health or the dental health of any minor or other individual for which I have responsibility, including arrangement and/or administration of any sedative (including nitrous oxide), analgesic, therapeutic, and/or other pharmaceutical agent(s), including those related to restorative, palliative, therapeutic or surgical treatments.

I understand that the administration of local anesthetic may cause an untoward reaction or side effects, which may include but are not limited to; bruising, hematoma, cardiac stimulation, muscle soreness, and temporary or rarely permanent numbness. I understand that occasionally needles break and may require surgical retrieval.

I understand that as part of the dental treatment including preventive procedures such as cleanings and basic dentistry, including fillings of all types teeth may remain sensitive ore even possible quite painful both during and after completion of treatment. After lengthy appointments, jaw muscles may also be sore or tender. Gums and surrounding tissues may also be sensitive or painful during and/or after treatment. Although rare, it is also possible for the tongue, cheek or other oral tissues to be inadvertently abraded or lacerated (cut) during routine dental procedures. In some cases, sutures or additional treatments may be required.

I understand that as part of dental treatment items including, but not limited to crown, small dental instruments, drill components, etc. may be aspirated (inhaled into the respiratory system) or swallowed. This unusual situation may require a series of x-rays to be taken by a physician or hospital and may, in rare cases require bronchoscopy or other procedures to ensure safe removal.

I understand the need to disclose to the dentist any prescription drugs that are currently being taken or that have been taken in the past, such as Phen-Fen. I understand that taking the class of drugs for the prevention of osteoporosis, such as Fosamax, Boniva and Actonel may result in complication of non-healing of the jawbones following oral surgery or tooth extractions.

I do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any which may be associated with general preventive and operative treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved for my benefit or the benefit of my minor child or ward. I acknowledge that the nature and purpose of the foregoing procedures have been explained to me if necessary and I have been given the opportunity to ask questions.

Print Name:_____

Signature:_____ Date:_____

(Parent or legal guardian or authorized agent of patient)

Witness:_____ Date:_____

Chase M. Williams, DDS, P.C.

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Health Insurance Portability Accountability Act (HIPAA), 1996

The Health Insurance Portability and Accountibility Act of 1996 provides safeguards to protect your privacy. The safeguards include restrictions on who may see or be notified of your Protected Health Information (PHI). The restrictions do not include the normal interchange of information necessary to provide you and your family with treatment. HIPPA provides certain rights and protections to you as the patient. We must balance these needs with our goal to providing you with quality service and care. For this reason, our practice has adopted the following policies:

(1) Patient Information will be kept confidential except as is necessary to provide treatment or to ensure that all administrative matters related to your care are handled appropriately. Patient files may be stored in open file racks but will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left in administrative areas such as the front office, Doctor's office, etc. The patient agrees to the normal procedures utilized within the facility for the handling of charts, patient records, PHI and other documents or information.

(2) It is the policy of this office to remind patients of their appointments. This may be done by telephoning patients or by any other means convenient for the practice.

(3) The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but agree to abide by the confidentiality rules of HIPPA

(4) The patient understands and agrees to inspections of the office and the review of documents which may include PHI by government agencies or Insurance companies in the normal performance of their duties.

(5) The patient agrees to bring any concerns or complaints regarding privacy to the attention of the Doctor or office manager.

(6) Your confidential information will not be used for the purpose of advertising or marketing of products, goods or services. Such prohibition does not include treatment, product samples or goods of normal value.

(7) The practice agrees to provide the patient with access to their records in accordance with state law.

(8) The practice may change, add, delete, or modify any of these provisions to better serve the needs of both the practice and the patient.

I, _____ do here by agree to the terms set forth above and any subsequent
Patient or Guardian

changes in office policy. I understand that this consent shall remain in force so long as I am a patient of this practice.

X_____ _____

Signature of Patient, parent or guardian **Date**

OFFICE FINANCIAL POLICIES AND FEDAREAL TRUTH-IN-LENDING STATEMENT

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from our patients for the costs incurred in their care to remain viable. Therefore, 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 rendered.

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 insurance claim forms for our patients or assist in making collections from the insurance company and will credit any such collections received to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid in full by an insurance company.

A service charge of 1 ½% per month and 18% annually of any unpaid balance will be assessed on all accounts exceeding sixty (60) days from the date of service unless previously written financial arrangements are made. I understand that a fee estimate listed for this dental care can only be extended for a period of six (6) months from the date of service.

In consideration for the professional services rendered to be rendered to me (or at my request, to my minor child or ward) by the dentist, I agree to pay the fees charged for the dental services provided by the dentist or the licensed employee at the time the services are rendered, or within five (5) days of billing if credit is extended by the dentist. In the event my account becomes delinquent, I agree to pay the remaining balance plus the sum of the collection commission fee charged by the collection agency, in addition to reasonable attorney fees and court costs where such legal services are necessary. The undersigned further agrees to pay an additional amount representing up to 40% of the principal balance if the account is referred to a collection agency or attorney for collections. This additional amount is in recognition of the cost associated with the said collection action processing. I authorize the release of financially identifiable information concerning my account, including charges billed, payments made, and interest charges assessed ect. to the dentist's collection agency or attorney should collection procedures as described become necessary.

I grant my permission to you or your assignee to telephone me at home or at my workplace to discuss matters related to this form. I also agree to let this office leave messages concerning appointments and/or results on my answering machine or with a family member.

This agreement supersedes all prior agreements signed, including any and all mediation or mediation/arbitration agreements. I acknowledge that any prior mediation/arbitration agreements signed previously related to financial arrangements or qualify of care are null and void.

I authorize the dentist or his designees to release financially identifiable information and treatment descriptions and information, either electronically, by facsimile or in paper form to my insurance carrier or any related entities that require such information to be submitted.

I acknowledge that I have received a copy of the office's privacy policies. I agree to disclose to the dentist name of any individuals with whom I authorize the dentist to discuss my dental care.

I certify that I have answered all questions accurately and to the best of my knowledge. I hereby agree to abide by the conditions outlined herein. A minimum fee may be charged for failed or cancelled appointments without a 24 hour notice.

_____	_____	_____
Signature of patient, parent or guardian	Date	Relationship to patient