Williams
FAMILY & COSMETIC DENTISTRY

NEW PATIENT FORMS

Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Preferred Phone #: _____ Preferred Email: _____

Date of Birth: _____ SS #: _____

Employer: _____

Dental Insurance: _____ Subscriber ID: _____ Group #: _____

Name of Insured (policy holder): _____

Primary Care Physician: _____ Primary Physician's Phone #: _____

RATE YOUR SMILE!

On a scale of 1-10, please let us know how you feel about your smile: ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

How would you like your smile to be rated?

_____

_____

_____

_____

_____

WE'RE GLAD YOU CHOSE WILLIAMS FAMILY & COSMETIC DENTISTRY!

Please let us know how you found us:

○ Direct Mail ○ Drive-by ○ Walk-in

○ Our website If you found us online, which search engine did you use? _____

○ Referral Please let us know who sent you so we can thank them: _____

○ Other (please explain) _____

_____

Thank you for choosing Williams Family & Cosmetic Dentistry—where we don't just strive to be very good, but to deliver EXCELLENT service to you, our patient, at every single visit.

8220 University Executive Park Drive, Suite 110, Charlotte, NC 28262 | (704) 547-8555 | www.WilliamsDentistryCLT.com

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DENTAL CARE HISTORY

Previous Dentist: _____

Approx. date of last visit: _____ Were X-rays taken at that visit? _____

What was done at that visit? _____

How often do you visit a dentist? _____ How often do you brush your teeth? _____

Floss? _____ Use other dental aids? _____

What problem are you having now and what brings you in for your first visit with us? _____

_____

_____

Please check if you have experienced any of the following:

Are your teeth sensitive to:

- ○ Hot
- ○ Cold
- ○ Sweets
- ○ Biting
- ○ Chewing

Do you:

- ○ Have sore or bleeding gums?
- ○ Have loose teeth or a change in your bite?

Do you:

- ○ Have bad breath or a bad taste in your mouth?
- ○ Get cold sores or other oral lesions?
- ○ Bite your lips or cheeks?
- ○ Routinely hold objects (pencil, pipe, pins, etc.) in your teeth?
- ○ Smoke/chew tobacco?
- ○ Clench or grind your teeth?

Do you:

- ○ Wear a bite splint or mouth guard?
- ○ Wake up with a tired jaw?
- ○ Hear clicking/popping of your jaw?
- ○ Have pain (in the joint, ear, or side of your face)?
- ○ Have difficulty opening/ closing your mouth?
- ○ Have difficulty chewing on either side?

Do you:

- ○ Have sore head, neck, or shoulder muscles?

Have you had:

- ○ Orthodontic treatment?
- ○ Oral surgery?
- ○ Periodontal treatment?
- ○ A bad dental experience? Please explain: _____

_____

_____

_____

Just a few more dental history questions...

Do/did your parents have gum disease or tooth loss? _____

Does food get caught in your teeth? Where? _____

Are you nervous about dental treatment? What is your biggest concern? _____

_____

How can we make your experience easier? _____

_____

Office Use Only

Dentist's signature: _____ Date: _____

Eaglesoft Medical History

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, c

Are you under a physician's care now?	◯ Yes ◯ No	If yes
Have you ever been hospitalized or had a major operation?	◯ Yes ◯ No	If yes
Have you ever had a serious head or neck injury?	◯ Yes ◯ No	If yes
Are you taking any medications, pills, or drugs?	◯ Yes ◯ No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	◯ Yes ◯ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	◯ Yes ◯ No	If yes
Are you on a special diet?	◯ Yes ◯ No	
Do you use tobacco?	◯ Yes ◯ No	
Do you use controlled substances?	◯ Yes ◯ No	If yes

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic
☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Other? ☐ If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive	◯ Yes ◯ No	Cortisone Medicine	◯ Yes ◯ No	Hemophilia	◯ Yes ◯ No	Radiation Treatments	◯ Yes ◯ No
Alzheimer's Disease	◯ Yes ◯ No	Diabetes	◯ Yes ◯ No	Hepatitis A	◯ Yes ◯ No	Recent Weight Loss	◯ Yes ◯ No
Anaphylaxis	◯ Yes ◯ No	Drug Addiction	◯ Yes ◯ No	Hepatitis B or C	◯ Yes ◯ No	Renal Dialysis	◯ Yes ◯ No
Anemia	◯ Yes ◯ No	Easily Winded	◯ Yes ◯ No	Herpes	◯ Yes ◯ No	Rheumatic Fever	◯ Yes ◯ No
Angina	◯ Yes ◯ No	Emphysema	◯ Yes ◯ No	High Blood Pressure	◯ Yes ◯ No	Rheumatism	◯ Yes ◯ No
Arthritis/Gout	◯ Yes ◯ No	Epilepsy or Seizures	◯ Yes ◯ No	High Cholesterol	◯ Yes ◯ No	Scarlet Fever	◯ Yes ◯ No
Artificial Heart Valve	◯ Yes ◯ No	Excessive Bleeding	◯ Yes ◯ No	Hives or Rash	◯ Yes ◯ No	Shingles	◯ Yes ◯ No
Artificial Joint	◯ Yes ◯ No	Excessive Thirst	◯ Yes ◯ No	Hypoglycemia	◯ Yes ◯ No	Sickle Cell Disease	◯ Yes ◯ No
Asthma	◯ Yes ◯ No	Fainting Spells/Dizziness	◯ Yes ◯ No	Irregular Heartbeat	◯ Yes ◯ No	Sinus Trouble	◯ Yes ◯ No
Blood Disease	◯ Yes ◯ No	Frequent Cough	◯ Yes ◯ No	Kidney Problems	◯ Yes ◯ No	Spina Bifida	◯ Yes ◯ No
Blood Transfusion	◯ Yes ◯ No	Frequent Diarrhea	◯ Yes ◯ No	Leukemia	◯ Yes ◯ No	Stomach/Intestinal Disease	◯ Yes ◯ No
Breathing Problems	◯ Yes ◯ No	Frequent Headaches	◯ Yes ◯ No	Liver Disease	◯ Yes ◯ No	Stroke	◯ Yes ◯ No
Bruise Easily	◯ Yes ◯ No	Genital Herpes	◯ Yes ◯ No	Low Blood Pressure	◯ Yes ◯ No	Swelling of Limbs	◯ Yes ◯ No
Cancer	◯ Yes ◯ No	Glaucoma	◯ Yes ◯ No	Lung Disease	◯ Yes ◯ No	Thyroid Disease	◯ Yes ◯ No
Chemotherapy	◯ Yes ◯ No	Hay Fever	◯ Yes ◯ No	Mitral Valve Prolapse	◯ Yes ◯ No	Tonsillitis	◯ Yes ◯ No
Chest Pains	◯ Yes ◯ No	Heart Attack/Failure	◯ Yes ◯ No	Osteoporosis	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No
Cold Sores/Fever Blisters	◯ Yes ◯ No	Heart Murmur	◯ Yes ◯ No	Pain in Jaw Joints	◯ Yes ◯ No	Tumors or Growths	◯ Yes ◯ No
Congenital Heart Disorder	◯ Yes ◯ No	Heart Pacemaker	◯ Yes ◯ No	Parathyroid Disease	◯ Yes ◯ No	Ulcers	◯ Yes ◯ No
Convulsions	◯ Yes ◯ No	Heart Trouble/Disease	◯ Yes ◯ No	Psychiatric Care	◯ Yes ◯ No	Venereal Disease	◯ Yes ◯ No
						Yellow Jaundice	◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X_____ Date:_____

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APPOINTMENT AGREEMENT

We make every effort to value your time and we schedule your appointment for you. We are committed to your oral health and keeping your reserved time allows us to be partners in your dental care.

We ask that you confirm your appointment a minimum of 2 business day prior. You may confirm via text, email or by calling our office during normal business hours. Failure to confirm your appointment may result in the loss of the time reserved for you and your treatment. Please note that we do no accept cancellations via our answering machine.

Missed/Broken Appointments: Any appointment that the patient does not keep or any appointment the patient cancels/changes within 2 business days' notice.

We will work hard to accommodate appointments that fit your schedule. We ask that you let us know about changes 48 hours in advance. We do understand that life happens, but any missed appointment without the 48 hour notice may be subject to a $50 short/no notice fee. Habitual missed appointments may result in a required deposit to schedule future appointments or possible dismissal from our office. If you keep the appointment, the payment will be applied towards your treatment

APPOINTMENT AGREEMENT

- I agree to provide a minimum of 2 business days' notice if I need to change my appointment for any reason
- If I change my appointment without the required 2 business days' notice within a 121 month span, I acknowledge I may be asked to prepay at the time of scheduling in order to be appointed
- I understand that I must confirm my appointment 2 business days' prior to my appointment or forfeit the appointment made for me and any and all deposits

Patient Signature: _____ Date: _____

DISMISSAL POLICY

When patients no show, cancel at the last minute, or show up late for their appointment, it greatly effects our schedule, as well as other patients appointments. In the event that you that you have more than 2 broken appointments, late cancellations, or frequently show up late for your appointment, you may be dismissed from our practice. Our voicemail does not accept any cancellations or changes to appointments; you will need to call back during normal business hours

We also ask that you abide by the following rules while in our office so that we can serve your dental needs in the best way possible:

- Cell phones are not to be used in the office. Please step outside if you need to make a call
- If you are more than 15 minutes late for your appointment, you may have to reschedule
- When you are late, it counts towards our dismissal policy
- If you do not have someone to watch your child/children that are under the age of 5, you will need to reschedule your appointment

I understand my responsibilities as outlined above and will abide by them.

Patient Name: _____ Date: _____

Patient/Guardian Signature: _____

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FINANCIAL AGREEMENT

Thank you for choosing Williams Family & Cosmetic Dentistry as your dental provider. Please understand that a financial agreement is an important part of the provider-patient relationship.

INSURANCE

We file insurance claims as a courtesy to you at no charge, and although we are on several Preferred Provider lists, **any insurance company can designate a procedure as "not covered".** There is no direct relationship between our office and your insurance company. Your insurance benefits are determined by the type of plan chosen by you and/or your employer and we are not party to this. We have no control over the terms of your contract of the determination of your benefits.

Your insurance company does not guarantee any payment of services until the claim we submit has been received and reviewed. Therefore, your portion of services performed in this office is only an **ESTIMATE** and due payable at the time of service. Even a preauthorization of services does not guarantee payment from your insurance carrier.

The ultimate responsibility of payment for services is with you.

Deposit Policy:

A non-refundable deposit will be required to reserve your desired procedure date and is due at the time of reserving the date.

You are welcome to reserve your procedure on the day of the exam. If you later realize that work or other scheduling conflict exist, your deposit will be fully credited towards a more convenient date as long as 2 business days' notice is given.

In order to receive full credit for your deposit, please notify our office at least 2 business days' prior to your scheduled procedure date. We understand that personal situations can arise unexpectedly and you may reschedule your procedure as often as necessary without penalty provided we receive 2 business day's advance notice.

I certify that I have read this form and fully understand and comply with the above financial agreement.

Signature: _____ Date: _____

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NOTICE OF PRIVACY PRACTICES

OUR "NOTICE OF PRIVACY PRACTICES" DOCUMENT PROVIDES DETAILED INFORMATION ON THE USE AND DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION.

You have the right to review the document prior to signing this consent form. (Our NOTICE OF PRIVACY PRACTICES document is subject to change. You can obtain a copy of the current notice by contacting us and requesting that a revised copy be mailed or given to you. **Williams Family & Cosmetic Dentistry** encourages you to read our NOTICE OF PRIVACY PRACTICES document in full.)

ACKNOWLEDGEMENT OF RECEIPT

I, the patient or patient's personal representative, have received a copy of the Williams Family & Cosmetic Dentistry HIPPA NOTICE OF PRIVACY PRACTICES document:

Patient/Parent/Guardian Signature:_____Date: _____

GOOD FAITH EFFORT AND REASON ACKNOWLEDGEMENT WAS NOT OBTAINED

If this acknowledgement of receipt is not obtained (in cases of emergency), a representative MUST document his/her good faith efforts to obtain the acknowledgement and the reason it was not obtained.

Patient refused to sign_____ Patient was unable to sign _____ Other_____

PERSONAL REPRESENTATIVE AUTHORIZATION

A personal representative is anyone you identify to have full authority to access or authorize review, release and/or copying of your/ patient's medical records, including but not limited to prescription refills and samples, reasons for visit and billing information.

○ I do not wish to select a personal representative

○ I authorize the following individual(s) to serve as my/patient's personal representative(s):

1._____2. _____

3._____4. _____

Please Note: If there are no names listed above, we will assume that you are declining your option to choose a personal representative and, in doing so, understand that our office will not give out any information, including prescription refills, to anyone other than you or the patient.

Patient/Parent/Guardian Signature:_____Date: _____

Furthermore, **I DO / DO NOT** (please circle one) authorize **Williams Family & Cosmetic Dentistry** to leave detailed information on my voicemail. I may revoke this authorization in writing at any time except to the extent that action based on this authorization has already taken place.

Patient/Parent/Guardian Signature:_____Date: _____

If forms have been completed by someone other than the patient, please PRINT that name here:_____

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HIPAA AUTHORIZATION FORM

FOR THE RELEASE OF IDENTIFYING HEALTH INFORMATION

I authorize Williams Family & Cosmetic Dentistry to release health information identifying me (including, if applicable, information about HIV infection or AIDS, substance abuse treatment, and mental health services) under the following terms and conditions:

1. A detailed description of the information to be released
2. The name(s) or class(es) of recipients that may receive the information
3. The purpose for the release (patient/guardian may state "at the request of the individual" if desired)
4. The expiration date/event for the purpose of the release

It is completely your choice whether to sign or not sign this form; we cannot refuse to treat you if you choose not to sign this authorization. If you do sign, you may revoke it later, except in cases when we have already acted in reliance upon this authorization. If you wish to revoke your authorization, please send us a written or electronic note stating that your authorization is revoked.

Please note: When your health information is disclosed as provided here, the recipient often has no legal duty to protect its confidentiality and may, if he/she wishes, disclose the information, although state or federal law could change this.

I have read and understand this form. I authorize the disclosure of my health information as described herein.

Sign: _____

You may request a copy of this form at the front desk.