Welcome!

Please take a few minutes to answer the following questions so we can better assist you with your dental needs.

Patient Information

Date ________ Soc. Sec. # ________ Birthdate ________

Name ________ (Last Name / First Name / Initial) Home Phone ________

Address ________ Cell Phone ________

City ________ State ____ Zip ____ E-mail ________

Sex: ☐M ☐F ☐Minor ☐Single ☐Married ☐Long Term Partner ☐Divorced ☐Widowed ☐Separated

Employer ________ Business Phone ________

Business Address ________ Occupation ________

Who should we thank for referring you? ________

In case of emergency, who should we contact? ________ Phone ________

Primary Insurance

Person Responsible for Account ________ (Last Name / First Name / Initial)

Relationship to Patient ________ Birthdate ________ Soc. Sec. # ________

Address ________ Home Phone ________

City ________ State ________ Zip ________

Responsible Party Employed By ________ Business Phone ________

Business Address ________ Occupation ________

Insurance Company ________

Insurance Company Address ________

Subscriber I.D. # ________ Group # ________

Additional Insurance

Insured Name ________ (Last Name / First Name / Initial)

Relationship to Patient ________ Birthdate ________ Soc. Sec. # ________

Address ________ Home Phone ________

City ________ State ________ Zip ________

Insured Employed By ________ Business Phone ________

Insurance Company ________

Insurance Company Address ________

Subscriber I.D. # ________ Group # ________

PATIENT CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- **Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)**
- **Obtaining payment from third party payers (e.g. my insurance company)**
- **The day-to-day healthcare operations of your practice**

I have also been informed of and given the right to review and secure a copy of your *Notice of Privacy Practices*, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this____ day of ___________, 20___.

Print Patient Name: ______________________________

Relationship to Patient: ___________________________

Signature: ______________________________________

Practice Name: Cory M. Williams DDS PLLC

Address 1125 Medical Center Dr. Wilmington NC 28401 Phone (910) 763-1072

City/State/Zip ______________________________

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Cory M. Williams DDS PLLC
1125 Medical Center Dr.
Wilmington NC 28401

OUR OFFICE POLICIES

FEES AND PAYMENTS:

All of our fees charged are based on **our** usual and customary fee schedule. You are required to pay any and all balances unpaid by your insurance. Treatment is charged out the day of service therefore **payments are due at the time of service**. Our office accepts Visa, Master Card, American Express, cash, and check. We do not accept partial payments however; we do understand they are sometimes necessary. To help accommodate your financial needs our office works with Care Credit, which offers different options to make payments affordable. See front staff for details.

MISSED APPOINTMENT POLICY

We understand things come up that you cannot control and appointments sometimes need to be broken, however, the time that is reserved for you is very important to you, Dr. Williams and the staff.
24 hours notice is required to avoid the $75.00 missed appointment fee.

INSURANCE

Dr. Williams is not a plan provider for your insurance however we have a great insurance team that works very hard to help maximize your insurance benefits. We will, **as a courtesy**, get a benefit break down of your coverage and submit the claim on your behalf. Feel free to ask questions about your coverage. We encourage you to share any information you may have about your insurance benefits that might help expedite the billing process. Any treatment not paid by your insurance company is your responsibility.

MINOR CHILDREN

Parents and or guardians of minor children MUST stay on the premises as long as the minor is on the premises. We encourage parents to NOT go in the back with the child. While the child is in the chair we cannot look out for your safety. If your child will not go in the back without a parent then we will refer him or her to a dentist that specializes in children.

I HAVE READ AND AGREE TO COMPLY WITH THE POLICIES ABOVE.

PATIENT/GUARDIAN	DATE	STAFF	DATE

Dental History

Former Dentist ____________________
City, State ____________________
Date of Last Dental Visit ____________________
Date of Last X-Rays ____________________
How Often Do You Floss? ____________________
How Often Do You Brush? ____________________

Please check all that apply:

- Bad Breath ☐
- Bleeding Gums ☐
- Blisters on Lips or Mouth ☐
- Finger Nail Biting ☐
- Grinding Teeth ☐
- Lip or Cheek Biting ☐
- Loose Teeth or Broken Fillings ☐
- Orthodontic Treatment ☐
- Pain Around Ear ☐
- Periodontal Treatment ☐
- Sensitivity to Cold ☐
- Sensitivity to Heat ☐
- Sensitivity to Sweets ☐
- Sensitivity When Biting ☐
- Frequent Headaches ☐
- Jaw, Head or Neck Injuries ☐
- Jaw Difficulty: Clicking and/or Pain.. ☐
- Tooth Pain ☐

Medical History

Physician's Name ____________________ Date of Last Visit ____________________

	Yes	No
1. Are you currently under medical treatment?	☐	☐
2. Have you ever had any serious illnesses or operations?	☐	☐
3. Are you currently taking any medication?	☐	☐

Please describe: ____________________

	Yes	No
4. Do you smoke?	☐	☐
5. Do you use alcohol, cocaine or other drugs?	☐	☐
6. Do you wear contact lenses?	☐	☐

7. Have you had any allergic reactions to the following:

	Yes	No
Local Anesthetics (eg. novocaine)	☐	☐
Penicillin or other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates (sleeping pills)	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Other	☐	☐

8. (Women Only) Are You:

	Yes	No
Pregnant?	☐	☐
Nursing?	☐	☐
Taking birth control pills?	☐	☐

Please check all that apply:

- AIDS ☐
- Anemia ☐
- Arthritis, Rheumatism ☐
- Artificial Heart Valves ☐
- Artificial Joints ☐
- Asthma ☐
- Back Problems ☐
- Bleeding abnormally, with extractions or surgery ☐
- Blood Disease ☐
- Cancer ☐
- Chemical Dependency ☐
- Chemotherapy ☐
- Chronic Fatigue Syndrome ☐
- Circulatory Problems ☐
- Congenital Heart Lesions ☐
- Cortisone Treatments ☐
- Cough - persistent or bloody ☐
- Diabetes ☐
- Emphysema ☐
- Epilepsy ☐
- Fainting or Dizziness ☐
- Glaucoma ☐
- Headaches ☐
- Heart Murmur ☐
- Heart Problems ☐
- Hepatitis-Type ______ ☐
- Herpes ☐
- High Blood Pressure ☐
- HIV Positive ☐
- Jaundice ☐
- Jaw Pain ☐
- Kidney Disease ☐
- Latex Sensitivity ☐
- Liver Disease ☐
- Low Blood Pressure ☐
- Mitral Valve Prolapse ☐
- Nervous Problems ☐
- Pacemaker ☐
- Psychiatric Care ☐
- Radiation Treatment ☐
- Respiratory Disease ☐
- Rheumatic Fever ☐
- Scarlet Fever ☐
- Shortness of Breath ☐
- Sinus Trouble ☐
- Skin Rash ☐
- Stroke ☐
- Swelling of Feet/Ankles ☐
- Swollen Neck Glands ☐
- Thyroid Problems ☐
- Tonsillitis ☐
- Tuberculosis ☐
- Tumor or growth on head/neck ☐
- Ulcer ☐
- Venereal Disease ☐

Assignment and Release

I hereby authorize payment directly to Cory M. Williams DDS PLLC for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

I authorize the above doctor and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party ____________________ Date ____________________