William E. Williams, DDS **Mark D. Pabst, DDS**

Welcome to the dental office of Drs. Williams & Pabst. Thank you for choosing our office to meet your dental needs. During your first appointment the doctor and his assistant will perform a comprehensive examination which will include any necessary x-rays. After the examination he will discuss his findings and any recommended treatment. The practice administrator will also be available to discuss any financial questions.

PATIENT REGISTRATION

About You

Today's Date _____

Mr. Mrs. Ms. Dr. _____
(LAST) (FIRST) (MI) (PREFERRED NAME)

Street Address: _____ P.O. Box: _____

City: _____ State: _____ Zip: _____ County: _____

❑ Male ❑ Female ❑ Single ❑ Married ❑ Divorced ❑ Widowed

Birthdate: _____ Age: _____ S.S.# _____

Home Phone #: _____ Work Phone #: _____ Ext. _____ Cell #: _____

Email: _____

Preferred appointment times: ❑ Morning ❑ Afternoon ❑ Anytime ❑ Mon. ❑ Tues. ❑ Wed. ❑ Thurs.

Employer: _____ Occupation: _____

Emergency Contact

In the event of an emergency, whom should we contact? _____ Relation: _____

Home Phone #: _____ Work Phone #: _____ Cell #: _____

About Your Spouse

His/Her Name: _____

Employer: _____ Occupation: _____

Work Phone #: _____ Ext.: _____ Cell #: _____

Our office believes that all people should have the opportunity to retain their natural teeth for a lifetime. Preventative measures, high quality care, and good cooperation combined with timely treatment make it possible for most people to retain their teeth with optimum comfort, function, and appearance. My staff and I are dedicated to this concept and with your cooperation we will do everything we can to help you reach your goals for good dental health.

Account Information

Person Financially Responsible for Account: _____

Relation to Patient: _____ S.S. #: _____

Billing Address: _____

Employer: _____ Work Phone #: _____ Ext.: _____ Home Phone #: _____

Dental Insurance

Insurance Company Name: _____ Insurance Co. Phone #: _____

Insurance Co. Address: _____ Group #: _____ Payor ID #: _____

Name of Policy Holder: _____ Relation: _____

Birthdate of Policy Holder: _____ Policy Holder's S.S. #/I.D.#: _____

Policy Holder's Employer: _____

Financial Responsibility

I understand the responsibility of payment for dental services provided in this office for myself or my dependents is mine. Payment is due and payable at the time services are rendered unless financial arrangements have been made. In the event of default, I promise to pay legal interest (1 1/2 % per month - 18% per annum), together with any collection costs and attorney fees as may be required to effect collection of this note. I agree to any inquiries as deemed necessary to establish credit with the office. Including a formal credit review. I hereby authorize payment of my dental insurance benefits directly to Drs. Williams & Pabst. I understand that my insurance carrier may pay less than the actual bill for services. I understand that I am financially responsibly for payment in full of all accounts by signing this agreement. **We allow your insurance company up to <u>45 days</u> from the date of service to pay your claim. After that time, we expect payment from you for the services rendered.**

_____ Date: _____ Relationship to patient: _____

Signature of guarantor of payment/responsible party

_____ Date: _____ Relationship to patient: _____

Signature of guarantor of payment/responsible party

The services that we provide for you are based on an agreement between you and our office. Your dental insurance relationship constitutes an agreement between you, your employer, and your insurance carrier. Please carefully review our policy regarding dental insurance and your responsibilities as the insured. Our dental team is here to help you and will be happy to answer any questions that you may have.

Medical History

Have you ever been under the care of a physician during the past two years other than routine visits? ❑ Yes ❑ No

If yes, for what? _____

Physicians name: _____ Phone: _____

Are you currently taking any medications, drugs or pills? ❑ Yes ❑ No

List: _____

Have you ever been told that you require premedication with antibiotics prior to dental treatment? ❑ Yes ❑ No

Comment: _____

I authorize permission to discuss premedication with a family member or leave a message. ❑ Yes ❑ No

Signature: _____

Are you aware of having an allergic or adverse reaction to any medication or substance? ❑ Yes ❑ No

List: _____

Name and phone number of your preferred pharmacy _____

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

An abnormal heart condition of any kind? ❑ Yes ❑ No
Specify: _____
Hepatitis [ ] A (infectious), [ ] B (serum), [ ] Other? ❑ Yes ❑ No
Artificial joints (hip, knees, etc.)? ❑ Yes ❑ No
Heart murmur/Mitral Valve Prolapse? ❑ Yes ❑ No
Artificial heart valve? ❑ Yes ❑ No
Rheumatic fever? ❑ Yes ❑ No
Arthritis/Rheumatism? ❑ Yes ❑ No
Kidney disease? ❑ Yes ❑ No
Dialysis? ❑ Yes ❑ No
High Blood Pressure? ❑ Yes ❑ No

Dementia? ❑ Yes ❑ No
Diabetes? ❑ Yes ❑ No
Thyroid disease/problems? ❑ Yes ❑ No
Respiratory disease/problems? ❑ Yes ❑ No
Neurologic disorders? ❑ Yes ❑ No
Liver disease? ❑ Yes ❑ No
Veneral disease? ❑ Yes ❑ No
A.I.D.S., or H.I.V. positive? ❑ Yes ❑ No
Epilepsy or Seizures? ❑ Yes ❑ No
Anemia? ❑ Yes ❑ No
Abnormal bleeding from a cut? ❑ Yes ❑ No
Cancer? ❑ Yes ❑ No

Additional information from above: _____

_____

Do you have or have you had any disease, condition or problem not listed above? ❑ Yes ❑ No

Explain: _____

Are you a tobacco user? ❑ Yes ❑ No

Do you have allergic skin reactions to metal jewelry? ❑ Yes ❑ No

Women: Are you pregnant? ❑ Yes ❑ No Nursing? ❑ Yes ❑ No Taking Birth Control Pills ❑ Yes ❑ No

Consent for Treatment

I understand that the information contained in the dental and medical histories is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. If further information is needed, you have my permission to ask my respective health care provider or agency who may release such information to you. I will notify Drs. Williams & Pabst of any changes in my health or medication. The undersigned hereby authorizes Drs. Williams & Pabst to take x-rays, study models, photographs or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the patient's dental needs. Upon such diagnosis, I authorize Drs. Williams & Pabst to perform all the recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care. I understand that using anesthetic agents embodies a certain risk. All diagnostic aids and documentation are the property of the practice. Original records may not be taken by the patient. All records are strictly confidential. **Signing this form authorizes us to transfer records from another dentist.**

Patient Signature _____ Date _____

Parent/Guardian Signature _____ Date _____

These are the things that are important to me about my Dental Health: (circle one)

1. My mouth is	a) very comfortable b) moderately comfortable c) uncomfortable
2. I I am	a) think the appearance of my mouth is excellent. b) satisfied with the appearance of my mouth. c) dissatisfied with the appearance of my mouth.
3. I	a) will do anything to keep my natural teeth. b) want to keep my teeth, but have a certain budget of time and money I am willing to spend on them. c) don't care whether I keep my teeth or not.
4. I	a) have set goals for my oral health with a previous dentist. b) want to set goals concerning my dental health. c) have never set goals concerning my dental health.
5. I	a) have always done what was recommended for my dental health. b) have not done what dentists have recommended for my mouth. c) rarely go, and don't care much about having dental work completed.
6. I have	a) put dentistry for myself and my family high on my priority list. b) put dentistry for myself and my family low on my priority list. c) it's on my list but hard to find.
7. I think my present state of dental health is:	a) excellent. b) good. c) poor.
8. I desire a mouth with:	a) excellent health. b) good health. c) poor health.

Snoring/Sleep Apnea

Do you snore or have you ever been diagnosed with sleep apnea? ❑ Snoring ❑ Sleep Apnea

_____

_____

Referral Source

Our practice is fortunate to receive referrals from friends and patients who have been pleased with the services that we provide.

- Is there someone we can thank for referring you to us? _____
- What is your immediate dental concern? _____
- What is the reason for your visit today? _____
- Regular care for the last 5 years? _____

WILLIAM E. WILLIAMS, DDS

Acknowledgement of Receipt Of Notice of Privacy Practices

Patient Name & Address: _____

_____

_____

I have access to a copy of the Notice of Privacy Practices for the above named practice.

_____ _____

Signature Date

For Office Use Only

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

- ☐ An emergency existed & a signature was not possible at the time.
- ☐ The individual refused to sign.
- ☐ A copy was mailed with a request for a signature by return mail.
- ☐ Unable to communicate with the patient for the following reason:

  _____
- ☐ Other: _____

  _____

Prepared By _____

Signature _____

Date _____

AUTHORIZATION TO RELEASE HEALTH INFORMATION

Communications between Patients and their Families, Friends, or Caregivers

This form allows _____ (Name of Practice) to communicate information about your care (e.g., appointments, labs, medication, treatment plans, billing information) to you and those you list on this form. Signing this form is optional, is not required to receive treatment, and does not expire until you end it in writing.

Patient Name: _____ (Last) _____ (First) _____ (Middle Initial)

Date of Birth: _____ mm/dd/yyyy **Main Contact Number:** (___) _____ ☐ Home ☐ Cell* ☐ Work

Mailing Address: _____ (Street)

_____ (City) _____ (State) _____ (Zip)

COMMUNICATING WITH YOU

PHONE	DETAILED MESSAGES PERMITTED		
☑ Main Contact Number Above	☑ text (SMS)*	☑ voicemail/answering machine	☐ None
☐ Other: (___) _____ ☐ Home ☐ Cell* ☐ Work	☐ text (SMS)*	☐ voicemail/answering machine	☐ None

EMAIL*

☑ _____

- ☐ All information from this practice
- ☐ Appointment information only (request/confirm/cancel)
- ☐ Data breach notifications
- ☐ Billing/insurance information

COMMUNICATING WITH YOUR FAMILY, FRIENDS, OR CAREGIVERS

☐ This practice may communicate to the family members, friends, or caregivers listed below.

Spouse/Partner: _____ First and Last Name
Phone: (___) _____
Email:* _____

Other: _____ First and Last Name
Phone: (___) _____
Email:* _____
Relationship: _____

Check the box next to each type of information this practice may share.

☑ All information ☑ Prescriptions ☑ Appointments (request/confirm/cancel) ☑ Billing/Insurance
☐ Other: _____

Do not include:

☐ Mental health records ☐ Communicable diseases (e.g., HIV/AIDS) ☐ Alcohol/drug abuse treatment

* I understand that emails and texts are not always secure ways to communicate and could be intercepted and read by a third party. I am willing to accept this risk.
This practice is not responsible for the privacy or security of your health information once it is sent to you, or the recipient(s) listed above.

YOUR PHOTOS & MULTIMEDIA

	Photos/Images may be used/posted:
☐ Photo received from you or personal representative	☐ In office
☐ Photo taken by staff (e.g., pre/post procedure)	☐ On office's website
☐ Other:_____	☐ Other: _____

PATIENT RIGHTS & SIGNATURE

- You can end this authorization at any time in writing. See our Notice of Privacy Practices for exceptions. A termination will not apply to any releases of information that happen before we receive a written termination from you.
- The recipient of the information could use or release it in a way that federal or state laws do not protect. This practice is not responsible for the privacy or security of your health information after it is sent to those listed on this authorization.
- You can review or copy the information that will be used or released as described in this authorization.
- You do not have to sign this authorization to receive treatment from this practice.
- You understand that the information that will be used or released might include a communicable disease diagnosis such as HIV or a diagnosis related to mental health or substance abuse unless you exclude it above.
- All changes or updates to this form must be made in writing and signed by you (patient) or your personal representative. Minor edits (e.g., new phone number) can be made on this form, initialed, and dated instead of requiring a new form.

_____ _____

Patient/Personal Representative Signature **Date:** mm/dd/yyyy

Printed name and description of Personal Representative's authority (e.g., healthcare power of attorney)
(Attach documentation to support the personal representative's authority if not already on file with the practice)

_____

FOR OFFICE USE & REFERENCE ONLY

☐ This authorization has been terminated: _____
mm/dd/yyyy

The termination must be in writing and filed with the original authorization.

Date original signed authorization received: _____
mm/dd/yyyy

☐ Copy of original authorization provided to patient/personal representative (check if yes)

Notes: _____

_____

_____

It is recommended that the practice review this form with the patient or their personal representative periodically for changes (e.g., annually with insurance verification).