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PATIENT NUMBER

PATIENT'S NAME _____
Last First Initial

Date _____ Date of Birth _____ Male Female

IF CHILD:
PARENT'S NAME _____
Last First Initial

DENTAL INSURANCE 1ST COVERAGE

EMPLOYEE NAME _____

EMPLOYEE DATE OF BIRTH _____

EMPLOYER _____ # YRS. _____

NAME OF INSURANCE CO. _____

ADDRESS _____

TELEPHONE _____

PROGRAM OR POLICY # _____

UNION LOCAL OR GROUP _____

SOCIAL SECURITY NO. _____

HOW DO YOU WISH TO BE ADDRESSED _____

Single Married Separated Divorced Widowed Minor

RESIDENCE - STREET _____

CITY _____ STATE _____ ZIP _____

BUSINESS ADDRESS _____

TELEPHONE: RES. _____ BUS. _____

PATIENT/PARENT EMPLOYED BY _____

PRESENT POSITION _____ HOW LONG HELD _____

SPOUSE/PARENT NAME _____

SPOUSE EMPLOYED BY _____

PRESENT POSITION _____ HOW LONG HELD _____

WHO IS RESPONSIBLE FOR THIS ACCOUNT _____

DRIVERS LICENSE NO. _____

METHOD OF PAYMENT: Insurance Credit Card Cash

PURPOSE OF CALL _____

OTHER FAMILY MEMBERS IN THIS PRACTICE _____

WHOM MAY WE THANK FOR THIS REFERRAL _____

PATIENT/PARENT SOCIAL SECURITY NO. _____

SPOUSE/PARENT SOCIAL SECURITY NO. _____

SOMEONE TO NOTIFY IN CASE OF EMERGENCY NOT LIVING WITH YOU _____

DENTAL INSURANCE 2ND COVERAGE

EMPLOYEE NAME _____

EMPLOYEE DATE OF BIRTH _____

EMPLOYER _____ # YRS. _____

NAME OF INSURANCE CO. _____

ADDRESS _____

TELEPHONE _____

PROGRAM OR POLICY # _____

UNION LOCAL OR GROUP _____

SOCIAL SECURITY NO. _____

RELEASE:

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

I authorize release of any information concerning my (or my child's) health care, advice and treatment to another dentist.

I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me.

I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services. I understand I am financially responsible for payments in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, in whole or in part by my dental care payor.

I attest to the accuracy of the information on this page.

PATIENT'S OR GUARDIAN'S SIGNATURE _____ DATE _____

REGISTRATION

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PATIENT NUMBER

WELCOME

Patient's Name _____
Last First Initial Date of Birth

1. Purpose of initial visit _____
2. Are you aware of a problem? _____
3. How long since your last dental visit? _____
4. What was done at that time? _____
5. Previous dentist's name _____
Address: _____ Tel. _____
6. When was the last time your teeth were cleaned? _____

COMMENTS

CIRCLE THE APPROPRIATE ANSWER. IF YOU DON'T KNOW THE CORRECT ANSWER, PLEASE WRITE "DON'T KNOW" ON THE LINE AFTER THE QUESTION.

7. Have you made regular visits?..... YES NO
How often: _____
8. Were dental x-rays taken? YES NO
9. Have you lost any teeth or have any teeth been removed? YES NO
Why? _____
10. Have they been replaced? YES NO
11. How have they been replaced?
 - a. Fixed bridge _____ Age _____
 - b. Removable bridge _____ Age _____
 - c. Denture _____ Age _____
 - d. Implant _____ Age _____
12. Are you unhappy with the replacement? YES NO
If yes, explain: _____
13. Would you like to know about permanent replacements? YES NO
14. Have you ever had any problems or complications with previous dental treatment?..... YES NO
If yes, explain: _____
15. Do you clench or grind your teeth?..... YES NO
16. Does your jaw click or pop?..... YES NO
17. Have you experienced any pain or soreness in the muscles of your face or around your ear?..... YES NO
18. Do you have frequent headaches, neck-aches, or shoulder aches?..... YES NO
19. Does food get caught in your teeth?..... YES NO
20. Are any of your teeth sensitive to: Hot? Cold? Sweets? Pressure?
21. Do your gums bleed or hurt? YES NO
When? _____
22. How often do you brush your teeth? _____ When? _____
23. Do you use dental floss?..... YES NO
How often? _____
24. Are any of your teeth loose, tipped, shifted, or chipped?..... YES NO
25. Are you unhappy with the appearance of your teeth? YES NO
26. How do you feel about your teeth in general?
27. Do you feel your breath is offensive at times?..... YES NO
28. Have you ever had gum treatment or surgery? YES NO
What? _____
Where? _____
When? _____
29. Have you had any orthodontic work?
30. Have you had any unpleasant dental experiences or is there anything about dentistry that you strongly dislike?
31. Do you have any questions or concerns?..... YES NO

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT'S / GUARDIAN'S SIGNATURE _____ DATE _____

DENTIST'S SIGNATURE _____ DATE _____

ANEST.

MED. ALERT

DENTAL HISTORY

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PATIENT NUMBER

WELCOME

Patient's Name _____
Last First Initial Date of Birth

1. Physician's Name _____
Address _____
Tel: () _____
2. Are you under a physician's care? YES NO
Since when _____ Why _____
3. When was your last complete physical exam? _____
4. Are you taking any medication or substances? YES NO
(If yes, please list medications in comments section or on the back of the form.)
5. Do you routinely take health related substances? (Vitamins, herbal supplements, natural products) YES NO
6. Are you allergic to any medications or substances? (please list) YES NO
7. Do you have any other allergies or hives? YES NO
8. Do you have any problems with penicillin, antibiotics, anesthetics
or other medications? YES NO
How often: _____
9. Are you sensitive to any metals or latex? YES NO
10. Are you pregnant or suspect you may be? YES NO
11. Do you use any birth control medications? YES NO
12. Have you ever been treated for or been told you might have heart disease? YES NO
13. Do you have a pacemaker or an artificial heart valve implant? YES NO
14. Have you ever had rheumatic fever? YES NO
15. Are you aware of any heart murmurs? YES NO
16. Do you have high or low blood pressure? (please circle) YES NO
17. Have you ever had a serious illness or major surgery? YES NO
If so, explain _____
18. Have you ever had radiation treatment, chemo treatment for tumor,
growth or other condition? YES NO
19. Do you have inflammatory diseases, such as arthritis or rheumatism? YES NO
20. Do you have any artificial joints/prosthesis? YES NO
21. Do you have any blood disorders, such as anemia, leukemia, etc.? YES NO
22. Have you ever bled excessively after being cut or injured? YES NO
23. Do you have any stomach problems? YES NO
24. Do you have any kidney problems? YES NO
25. Do you have any liver problems? YES NO
26. Are you diabetic? YES NO
27. Do you have fainting or dizzy spells? YES NO
28. Do you have asthma? YES NO
29. Do you have epilepsy or seizure disorders? YES NO
30. Do you or have you had venereal disease? YES NO
31. Have you tested HIV positive? YES NO
32. Do you have AIDS? YES NO
33. Have you had or do you test positive for hepatitis? YES NO
34. Do you or have you had T.B.? YES NO
35. Do you smoke, chew, use snuff or any other forms of tobacco? YES NO
36. Do you regularly consume more than one or two alcoholic beverages a day? YES NO
37. Do you habitually use controlled substances? YES NO
38. Have you had psychiatric treatment? YES NO
39. Have you taken any prescription drugs fenfluramine, fenfluramine combined with
phentermine (fen-phen), dexfenfluramine (redux), or other weight loss products? YES NO
40. Do you have any disease condition, or problem not listed? If so, explain _____
41. Is there anything else we should know about your health that we have not covered in this form?

42. Would you like to speak to the Doctor privately about any problem? YES NO

COMMENTS

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT'S / GUARDIAN'S SIGNATURE _____ DATE _____

DENTIST'S SIGNATURE _____ DATE _____

ANEST.

MED. ALERT

DENTAL HISTORY

Dr. J. Michael Williams, DDS

**ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES**

You may refuse to sign this acknowledgement

I, _____, have received a copy of this office's Notice of Privacy Practices.

(Please print name)

(Signature)

(Date)

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining the acknowledgement
- Other (please specify)

FINANCIAL POLICY

Our practice is committed to provide the highest quality care to our patients. The patient is ultimately responsible for fees incurred for these services. Many patients have contracts with various insurance carriers for assistance in these payments. As a courtesy to our patients, we will assist in proper reimbursement entitled under these policies. We make every effort to estimate the coverage for each patient prior to each visit based on information provided by these companies. After reimbursement, we will promptly refund any overpayment from the insurance company or bill the patient for the unpaid portion. Our fees are based on averages from the providers in this area. The fees specified by each insurance carrier, however, may differ from area practices. THE ULTIMATE RESPONSIBILITY FOR PAYMENT RESTS WITH THE PATIENT. If any payment is made directly to you for services billed by us, you recognize an obligation to promptly remit the same to Dr. Williams. We appreciate the confidence you've placed in our practice and urge you to speak with our financial counselor with any questions.

I understand the above information and understand my responsibility for the payment of my account.

Patient/Responsible Party

Date

Witness

Date



J. Michael Williams, D.D.S.

600 Erwin Road, Dunn, NC 28334 · (910) 891-5000 · Fax (910) 891-5500

October 18, 2007

Dear Patients,

We have prepared this letter to help you better understand the complexities of dental insurances; we realize how confusing it can be. To begin, we would like to highlight a misconception—dental insurance was not designed to pay for all dental care. Most contracts have limits and/or various degrees of co-payments.

All levels of payment by insurance companies, including allowed fees, usual and customary (UCR) are governed by the premiums paid. They have nothing to do with the actual charges. Our fees are based upon a combination of our costs, our time and our constant dedication to supplying our patients with the highest quality dental care. The treatment recommended by our office is never based on what your insurance company will pay; your treatment should not be governed by your insurance contract.

However, it should be understood, that the dental insurance contract is between the insurance company and the patient, who bears the ultimate financial responsibility.

We hope this information has been helpful. Please take time to review your contract thoroughly so we may best serve you. As always, you may feel free to ask any member of our staff for clarification on services, billing, and insurance.

_____ (Signature)

_____ (Print Name)

_____ (Date)

J. Michael Williams, DDS

JMW/swb