Welcome Form

Dr. J. Michael Williams

Patient:

First name:_____

Middle Initial:_____

Last Name:_____

Preferred Name:_____

Address:_____

City:_____ State:_____Zip:_____

Home Phone:_____

Work Phone:_____

Cell Phone:_____

Sex: M F

Marital Status: Single Divorced Widowed Separated Married

DOB:_____

Social Security: _____-____-_____ (Must Have to file Insurance)

Email:_____

Would you like to receive email notifications: Y N

Would you like to receive text message notifications: Y N

Primary Insurance:

Policy Holder: _____

If not self, need policy holders DOB and Social _____

Relationship to Patient:_____

Employer :_____

Insurance Co: _____

Secondary Insurance:

Policy Holder: _____

Relationship to patient: _____

Employer: _____

Insurance Co:_____

How did you hear about us:_____

Pharmacy:_____

List Responsible Party if not self:

Full Name:_____

Address:_____

City:_____ State:_____ Zip:_____

Phone

Dr. J. Michael Williams, P. A.

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, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Please list your primary care provider. Please list your preferred pharmacy.	◯ 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:_____

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

I, _____, hereby acknowledge that I have received and reviewed a copy of **J. Michael Williams, DDS, PA** 's *HIPAA Notice of Privacy Practices.*

I understand that **J. Michael Williams, DDS, PA**'s *HIPAA Notice of Privacy Practices* may change periodically and that I am entitled to receive a copy of **J. Michael Williams, DDS, PA**'s revised *HIPAA Notice of Privacy Practices* upon request.

I understand that, if I have questions about J Michael Williams, DDS, PA *Notice of Privacy Practices*, I may contact Johnna L Hill, 600 Erwin Rd, Dunn NC.

I understand that it is my right to refuse to sign this Acknowledgement should I so choose, and that **J. Michael Williams, DDS, PA** will not refuse treatment to me if I refuse to sign this Acknowledgement.

I further understand that I may contact the Secretary of the U.S. Department of Health and Human Services should I have concerns regarding **J. Michael Williams, DDS, PA** 's privacy policies and procedures. For information on how to contact the U.S. Department of Health and Human Services, please ask, Johnna L Hill, noted above, for assistance.

_____ _____

Patient Signature Date

_____ _____

Signature of Personal Representative Print Name/Relationship of Representative

FOR OFFICE USE ONLY

J. Michael Williams, DDS, PA made a good-faith effort to obtain Acknowledgement, from the patient noted above, of receipt of its *HIPAA Notice of Privacy Practices*. In spite of these efforts, **J. Michael Williams, DDS, PA** was unable to obtain a signed Acknowledgement for the following reason(s):

- ☐ Refusal to sign Acknowledgement on _____,20
- ☐ Communication barrier prohibited us from obtaining a signed acknowledgement.
- ☐ An emergency prohibited us from obtaining a signed Acknowledgement.
- ☐ Other (Describe):

CANCELLATION OF AN APPOINTMENT:

In order to be respectful of other patient's needs, please be courteous and call our office promptly if you are unable to attend an appointment. This time will be given to someone who is in urgent need of treatment. Any appointment(s) not cancelled 2 business days in-advance is subject to a $80 cancellation fee.

NO SHOW POLICY:

A no show is an appointment that was not canceled in-advance. No shows inconvenience other patients who need dental care and can cost the practice a lot of money by having the doctor and staff idle. This ultimately increases costs for everyone. A no show for a scheduled appointment will therefore result in a fee of $80 for every hour of scheduled appointment time. After 2 occurrences, we reserve the right to dismiss the patient from the practice.

Additional Q&A on cancellation fees:

"My previous dentist didn't have missed appointment fees, why do you?"

Our office is proud of the quality of patient care we provide. We try our best to respect each patients time and we ask the same from you. Because we will not compromise the service and quality of patient care, we need to address the cancellation issue head-on. There are two options for our practice when a patient no-shows for an appointment. The first choice is for the practice to sit idle and absorb staff, rent, utilities, and doctor time with no offsetting revenue. The second option, which our office refuses to do, is to over-book the schedule. We don't like over-booked schedules and we're sure you don't either. This typically means hectic dentist schedules, hectic staff schedule, long-waits for the patient, and rushed patient care.

"There are probably just a few cancellations a month, right? How much could that cost you?"

If only that were true! Before implementing a cancellation fee policy we could experience 2 or 3 last-minute cancellations or no-shows each day. That might be 20-30% of the daily schedule. We understand some patients have a dental phobia or last minute plans are made, but unfortunately those cancellations quickly turn a profitable practice into an unprofitable practice. We're sure everyone has a valid reason for each missed appointment, but unfortunately those reasons don't pay the rent, staff, utilities, etc.

"My boss just made me work late and can no longer make my appointment. Are you really going to charge me?"

Sorry, but yes. By canceling last minute, we do not have enough time to schedule another patient. This causes us to suffer financially for your actions, or for the actions of others outside our control. You've made a personal commitment to our practice and, in return, we've reserved doctor and staff time specifically for your appointment. If your boss made you stay late when you had concert tickets, the band wouldn't hold the show. Similarly if you missed a flight, the airlines don't give you a free pass. A lot of people ask us to understand their situation when they can't make an appointment last minute – and we do listen – but please also consider our point of view.

"Nobody called to remind me of my appointment, do I still have to pay?"

Yes. Our office goes to great lengths to provide courtesy reminders for appointments. We don't want you to forget about your appointment, but once you've scheduled with us, the responsibility is still yours to keep the appointment or cancel within the allotted timeframe. Whether we are successful in reaching you before-hand or not, the responsibility is still yours. Currently, our office attempts to remind every patient of each appointment by a personal phone call, text message, and email.

If anyone has additional questions or comments, please do not hesitate to contact us. We know this policy isn't popular, but it has become necessary to operate (we are all ears if someone has other suggestions). If you don't agree, that's OK too. We can't be all things to all people. If your schedule is constantly changing, you might be better served by another practice, and we'll help recommend other dentists in the area. Our focus will remain the same: provide outstanding patient care at affordable prices, which is only possible when patients help do their part as well.

Thanks for listening.

_____ Signature

_____ Print

_____ Date