WILLIAMS
DENTAL AND ASSOCIATES

100 Market Place Dr. | Suite B • Byram, MS 39272 Phone: (601)-665-4809 Fax: (769)-230-4973

New Patient Paperwork

Patient Name: _____ _____ _____
Last First MI

Preferred Name: _____

Gender: ☐ Male ☐ Female **Status**: ☐ Married ☐ Single ☐ Child ☐ Other

DOB: _____/_____/_____ **SS#** _____ - _____- _____

Email Address: _____

Phone: _____ _____ _____
Mobile Home Work

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Whom may we thank for referring you to our practice? _____

The following information is for: ☐ Patient ☐ Person responsible for payment ☐ Both ☐ Other _____

Employer Information:

Employer Name _____ **Phone:** _____

Employer Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Emergency Contact Information:

Name: _____ **Phone:** _____

Relationship to Patient: _____

****Notice of Privacy Practices Acknowledgement ****

The privacy of your health information is important to us. Our notice of Privacy Practices describes how your health information will be handled in various situations. We ask that you sign this form to acknowledge that you have received a copy of our Notice of Privacy Practices

☐ By checking this box, I acknowledge that I have received a copy of the dental practice's Notice of Privacy Practices

Signature of patient, parent, or guardian (responsible party): _____

Relationship to Patient: _____ **Date:** _____

Primary Dental Insurance:

☐ No Dental Insurance

Name of Insured: _____ _____ _____
Last First MI

Insured DOB: _____/_____/_____ **Insured SS#** _____-_____-_____
Month Day Year

Insured Address: _____ ☐ Same as Patient's Address

City: _____ **State:** _____ **Zip Code:** _____

Name of Insurance: _____

ID#: _____ **Group #** _____

Insurance Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Patient Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Authorization:

☐ By checking this box,
I authorize my insurance to pay my benefits directly to the dentist for all services rendered.
I authorize the use of this electronic signature off all insurance submissions.
I authorize the dentist to release all information necessary to secure the payment of benefits.
I understand that I am financially responsible for all charges, whether or not paid by the insurance.

******Dental Practice Financial Policy*******

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment. As consistent with applicable laws and the policies of the patient's applicable dental insurance or other third-party payer coverage, we require the following:

- All emergency dental services and any dental services performed without previous financial arrangements must be paid for in cash at the time services are rendered.
- All dental services are charged directly to the patient and the patient is personally responsible for payment of all dental services, even if the patient carries dental insurance. This office will, as a courtesy, help prepare the patient's insurance forms and may assist in making collections from dental insurance companies, and will credit any collections from insurance to the patient's account.
- Fee estimates for dental care can only be extended for a period of six months from the date of consultation.
- Payment for services is due at the time of treatment, or if billed by this office, payment is due within thirty (30) days of billing.
- Charges for services shall be as billed unless objected to, by the patient, in writing, within the time payment is due.

☐ By checking this box, I acknowledge that I have read, and fully understand and agree to the terms of this Financial Policy.

Medical History

Indicate which of the following you have had or have at present. By checking the circle, it will indicate a "Yes" response, leaving blank will indicate a "No" response.

o Pre-Med - Amox	o *Pre-Med - Clind	o *Pre-Med - Other	o Allergies
o Allergy - Aspirin	o Allergy - Codeine	o Allergy - Erythro	o Allergy- Hay Fever
o Allergy - Latex	o Allergy - Other	o Allergy - Penicillin	o Allergy - Sulfa
o Anemia	o Anxiety	o Arthritis	o Artificial Joints
o Asthma	o Blood Disease	o Cancer	o Diabetes
o Dizziness	o Epilepsy	o Excessive Bleeding	o Fainting
o Glaucoma	o Head Injuries	o Heart Disease	o Heart Murmur
o Hepatitis	o High Blood Pressure	o HIV	o Hypothyroidism
o Hysterectomy	o Jaundice	o Kidney Disease	o Liver Disease
o Mental Disorders	o Multiple Sclerosis	o Nervous Disorders	o Venereal Disease
o Pacemaker	o Pregnancy	o Radiation Treatment	o Respiratory Problems
o Rheumatic Fever	o Rheumatism	o Sinus Problems	o Stomach Problems
o Stroke	o Tuberculosis	o Tumors	o Ulcers
o Other (Please specify):			
o Ever been hospitalized (illness or injury)		o Presently being treated for any other illnesses	
o Taking medication for weight control (ie fen-phen)		o Taking dietary supplements	
o Subject to frequent headaches		o A smoker or smoked previously	
o FEMALE: Taking birth control pills		o FEMALE: Pregnant	

If any condition or alerts selected above needs further clarification, please explain below:

_____

_____

Do you take antibiotic premedication for your dental visits? If yes, please explain.

_____

_____

Name of physician and their specialty:

_____

_____

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment:

_____

_____

List all medications, supplements, and/or vitamins taken within the last two years:

_____

_____

☐ By checking this box, I acknowledge that the above information is correct and I understand it is my responsibility to inform the office of any changes in my health as soon as possible.

Dental Information

Previous Dentist name and how long were you a patient there: _____

Date of most recent dental exam: _____ Date of most recent dental x -rays: _____

Immediate Concern: _____

_____

Personal History, check all the apply:

- o Had an unfavorable dental experience
- o Had any reactions to local anesthetic
- o Had any teeth removed
- o Had complications from past dental treatment
- o Had/have braces, orthodontic treatment
- o Had trouble getting numb
- o Had your bite adjusted

WILLIAMS
DENTAL AND ASSOCIATES

Gary E. Williams, DMD
100 Market Place, Suite B
Byram, MS 39272

Patient Photo Release Form

I hereby authorize Dr. Williams and/or any of his staff to take photographs, slides, and/or videos of my face, jaws, and teeth.

I understand that the photographs, slides, and/or videos will be used as a record of my care, and may be used for educational purposes in lectures, demonstrations, advertising (including website publication, newspapers, magazines, phone books, television), and professional publications (dental magazines and journals).

I further understand that if the photographs, slides, and/or videos are used in any publication or as part of a demonstration, my name (First Name) Only or other identifying information could be used unless stated differently below. I do not expect compensation, financial, or otherwise, for the use of these photographs.

Please Initial:

_____ I do not mind if my first name, face, and teeth are used in any of the above stated situations.

Exceptions:

_____ I do not wish to have my First Name shown, or released.

_____ I do not wish to have my face shown.

_____ I only agree to have my teeth shown without any identifying features.

_____ I do not wish to have my photos used at all.

Patient Name: _____

Patient/Guardian Signature: _____

Date: _____