Derrick L. Williamson, DDS, MS, PC

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Welcome to our office. We appreciate the confidence you place with us to provide dental services. To assist us in serving you, please complete the following form. The information provided on this form is important to your dental health. If there have been any changes in your health, please tell us. If you have any questions, don't hesitate to ask.

Patient Information

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. ☐Rev. ☐ Pastor ☐ Sister

Date: _____

Name: _____ M.I._____ Last Name_____ Nickname_____

Sex: ☐ Male ☐ Female Date of Birth: _____ Age: _____ Soc. Sec. #_____

Address: _____City: _____ State: _____ Zip: _____

Home Tel: _____Cell: _____E-mail: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widow

Employer: _____ Occupation: _____

Bus. Tel: _____ Ext: _____

Family Physician: _____Tel: _____

Emergency Contact

Name: _____Relationship to patient_____

Home Tel: _____Work Tel: _____Cell: _____

Who will be responsible for your account?

(If self, skip to next section)

☐ Self ☐ Spouse ☐ Father ☐ Mother ☐ Student ☐ Other _____

Name: _____S.S#: _____ Date of Birth_____

Address (If different):_____ City: _____ State:_____ Zip:_____

Dr. Williamson is a ''Fee for Service" doctor and is not contracted with any insurance company, however if we can obtain your insurance information we will bill your insurance company and they will reimburse you directly.

Dental Insurance

Dental Coverage? ☐ Yes ☐ No

Primary Ins. Co. Name: _____

Insurance Co. Address: _____ Insurance Co. Tel: _____

Group # (Plan, Local or Policy):_____Group Name: _____

Subscriber's name: _____ Subscriber ID#:_____

Date of birth: _____ SS#:_____ Relationship to patient: _____

Secondary Ins. Co. Name: _____

Insurance Co. Address: _____ Insurance Co. Tel: _____

Group # (Plan, Local or Policy):_____Group Name: _____

Subscriber's name: _____ Subscriber ID#:_____

Date of birth: _____ SS#:_____ Relationship to patient: _____

FEES AND PAYMENTS

We make every effort to keep down the cost of your dental procedures. You can help by paying upon completion of each visit. Other arrangements can be made with our office manager depending upon special circumstances. An estimate of the charge for any procedure will be given to you. If you have any dental and/or medical insurance we will be glad to fill out the proper forms, but please complete the identifying information on this form. Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. **Because we are not contracted with any insurance company, we will bill your insurance company for you and they will reimburse you directly. If your account goes into collection you will be responsible for all collection costs, attorney's fees, and court costs.**

Signature of patient: *(Parent or Guardian minor)* _____**Date:**_____

This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to this doctor named of the benefits otherwise payable to me.

Signature of patient: *(Parent or Guardian minor)* _____**Date:**_____

DENTAL HISTORY

Name of current dentist: _____ Tel: _____

Date of last visit to dentist: _____

Referred to us by: _____ Tel: _____

Do you have, or have you had, any of the following….	***YES***	***NO***
Do you clench or grind your jaws frequently?		
Does your jaw get stuck so that you can't open freely?		
Does it hurt when you chew or open wide to take a bite?		
Does jaw pain or discomfort affect your appetite, sleep, daily routine, or other activities?		
Do you have a temporomandibular (jaw) disorder (TMD)?		
Do you have pain in the face, cheeks, jaws, joints, throat, or temples?		
Are you unable to open your mouth as far as you want?		
Have you had a blow to the jaw (trauma)?		
Are you a habitual gum chewer or pipe smoker?		
Have you had problems with previous dental treatment?		
Do you gag easily?		
Do you wear dentures?		
Does food catch between your teeth?		
Do you have difficulty in chewing your food?		
Do your gums bleed easily?		
Do your gums bleed when you floss?		
Do your gums feel swollen or tender?		
Have you ever noticed slow-healing sores in or about your mouth?		
Are your teeth sensitive?		
Do you take fluoride supplements?		
Do you feel twinges of pain when your teeth come in contact with:		
Cold foods or liquids?		
Sours?		
Sweets?		

***MEDICAL HEALTH HISTORY*:**

Name of your medical doctor: _____ Tel: _____

Date of last visit to medical doctor: _____

Are you in good health? _____ Height_____ Weight_____

Do you have, or have you had, any of the following….	***YES***	***NO***
Rheumatic fever?		
Damaged heart valves / mitral valve prolapse?		
Heart murmur?		
High blood pressure?		
Low blood pressure?		
Chest pain / angina?		
Heart attack(s)?		
Irregular heart beat?		
Cardiac pacemaker?		
Heart surgery?		
Bronchitis, chronic cough?		
Asthma?		
Hay fever / sinus problems?		
Snoring / sleep apnea?		
Difficult breathing / other lung trouble?		
Tuberculosis?		
Emphysema?		
Do you smoke?		
Do you use chewing tobacco?		
Blood transfusion?		
Blood disorder such as anemia?		
Bruise easily?		
Bleeding tendency / abnormal bleed?		
Hepatitis, jaundice, or liver disease?		
Infectious mononucleosis?		
Gallbladder trouble?		
Fainting spells?		
Convulsions / epilepsy?		
Stroke?		
Joint replacement? (e.g., total hip, pins, or implants)		

Do you have, or have you had, any of the following….	***YES***	***NO***
Thyroid trouble?		
Diabetes?		
Low blood sugar?		
Kidney trouble?		
Are you on dialysis?		
Swollen ankles, arthritis or joint disease?		
Osteoporosis / Osteopenia?		
Osteonecrosis?		
Stomach ulcers?		
Contagious diseases?		
Sexually transmitted diseases?		
Are you immunosuppressed? possibly from transplant surgery, etc.		
Problems with the immune system? possibly from medication / surgery, etc.		
Delay in healing?		
A tumor or growth?		
Radiation therapy / chemotherapy?		
Chronic fatigue / night sweats?		
Are you on a diet?		
A history of drug abuse?		
A history of alcohol abuse?		
Contact lenses?		
Eye disease / glaucoma?		
Mental health problems?		
A removable dental appliance?		
Pain and clicking of jaws when eating?		
Malignant hyperthermia?		
IF YOU ARE HAVING SURGERY TODAY, have you had anything to eat or drink in the last 6 hours?		
Who is driving you home?		

During the past 12 months, have you taken or are now taking any of the following…..?	***YES***	***NO***
Antibiotics or sulfa drugs?		
Blood thinners? (e.g., Coumadin)		
High blood pressure medicine?		
Tranquilizers?		
Insulin, Orinase, or similar drug?		
Aspirin?		
Digitalis or drugs for heart trouble?		
Nitroglycerin?		
Cortisone? (steroids)		
Nonprescription drug/supplements?		
Sleeping Pills?		
Anti-Depressants?		
Medication for Osteoporosis / Osteopenia?		
Other?		

Please list any other medications you are currently taking: _____

_____

_____

Premedication's required by physician: _____

_____

Women	***YES***	***NO***
Is there a possibility of pregnancy? If so, expected delivery date:		
Are you nursing?		
Have you reached menopause?		
If so, do you have any symptoms?		
Are you taking contraceptives or other hormones?		

Women Note: Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician / gynecologist for assistance regarding additional methods of birth control.

Is there a FAMILY HISTORY of…..?	***YES***	***NO***
Cancer?		
Diabetes?		
Heart Disease?		
Anesthetic Problems?		

Are you allergic, or have you reacted adversely, to any of the following…..?	***YES***	***NO***
Local anesthetics ("Novocain")?		
Penicillin?		
Other antibiotic?		
Sulfa drugs?		
Sodium pentothal, Valium, or other tranquilizers?		
Aspirin, Acetaminophen, or Ibuprofen?		
Codeine, Demerol, or other narcotics?		
Other medications?		
Latex or rubber dam?		
Reaction to metals?		
Soy?		
Eggs / Yolk?		
Sulfites?		

Please list any allergies other allergies: _____

_____

Is there any conditions concerning your health that the Doctor should be told about?

☐ Yes ☐ No (If so, describe) _____

_____

I certify that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my surgeon, or any other member of his / her staff, responsible for any errors or omissions that I have made in the completion of this form.

Signature of patient: *(Parent or Guardian minor)* _____ **Date:** _____

Witness: _____ _____ Date: _____

(Print) (Signature)

Dr. Derrick Williamson
Prosthodontics

NOTICE OF PRIVACY PRACTICE SUMMARY

This summary discloses how healthcare Information about you may be used by Dr. Derrick Williamson. A full notice of your privacy rights has been provided to you.

Treatment, Payment and Operations. We may use health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive.

Uses and Disclosures for Appointment Reminders. We may use and disclose your Healthcare information to contact you as a reminder that you have an appointment at the office. If you request that such communications be made confidentially, please contact our office in writing. We will accommodate all reasonable requests.

Authorization for Use and Disclosure. We may not disclose your information to other unless you tell us in writing to do, or unless the law authorizes us to do so.

Public health, research, health and safety, government, workers compensation. We may disclose your information for public health activities, research, health and safety, governmental fictions, and in order to comply with workers compensation laws and regulations.

Rights. You have the right to inspect and copy information used to make decisions about your care, to request an amendment of the information, to an accounting of disclosures, to request communication with you by alternate means, to request restrictions on the information we use, and to revoke you r authorization for release of information.

Complaints. You may complain to the Privacy Information Director at (630)961-5850 or to the Department of Health and Human resources if you believe your privacy right has been violated. You will not be retaliated against for filing a complaint

Organization duties. We must maintain the privacy of protected health information, provide you with notice of our legal duties and privacy practice with respect to your health information, abide by the terms of the notice, notify you if we are unable to agree to the requested restriction on how your information is used or disclosed, accommodate reasonable request you may make to communicate with health information by alternative means or by alternative locations, and obtain your written authorization to use or disclose your health information for reasons other than those listed above and permitted under laws.

Questions. If you have and questions, please contact the Privacy office at 630-961-5850.

"I acknowledge that I have received the full Privacy Notice"

Print Name: _____ Signature_____ Date: _____

Witness Name: _____ Signature: _____ Date: _____

Cancelation Notice

Restorative and Hygiene Appointment

We ask for at least 48 hours advance notice for canceling or rescheduling an appointment; otherwise, a $125.00 fee may be assessed to your account.

Note: All cancellation fees must be paid prior to scheduling another appointment.

The treatment that is planned for you is specific to you. It is important for you to keep the scheduled dates and times to properly complete your treatment. A broken appointment is a loss to three people --- the patient who missed the valuable time, the patient who could have taken the valuable time; and the doctor who was fully staffed and prepared for the appointment.

_____ _____

Signature Date

Acknowledgement and Release

Insurance

We provide services for our patients with the understanding that they are responsible for payment in accordance with our financial policy. We will prepare, submit forms and reports to assist you in obtaining maximum benefits available, however the dentist's treatment recommendations or fees are not affected by the presence or absence of insurance benefits. Treatment recommendations are based on your dental needs and desires and are not a reflection of your dental benefits. Your dental benefits are a contract between you, your employer and the insurance company; therefore we **do not confirm** insurance eligibility or predetermine recommended treatment. We are not preferred providers, members or have any association with any insurance organizations.

Collections

In the event the balance becomes more than 60 days overdue, billing may be turned over to an outside collection agency. The responsible party listed above agrees to pay interest, collection and other legal expenses related to collection of fees owed. Waiver of any breach of any time or condition shall not constitute a waiver of any further term or condition.

_____ _____

Signature Date