GREENVILLE DENTAL SLEEP CENTER William E. Williams, DDS

Welcome to our practice. This confidential information will help us care for and communicate with you.
Please fill out this form as completely as possible.

ABOUT YOU Date: _____

Name: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. _____
Last First MI Preferred

Address: _____

City: _____ State: _____ Zip: _____

Birthdate: _____ Age: _____ Social Security #: _____

Gender: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Home Phone: _____ Work Phone: _____ Wireless Phone: _____

Email: _____

Preferred Contact Method: ☐ Home Phone ☐ Work Phone ☐ Wireless Phone ☐ Email ☐ Text Message

Employer: _____ Occupation: _____

Sleep Physician: _____ Phone: _____

Primary Physician: _____ Phone: _____

Dentist: _____ Phone: _____

Our practice is fortunate to receive referrals from friends, patients, and collegues who have been pleased with the services we provide.
Is there someone we can thank for referring you to us? _____

EMERGENCY CONTACT

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

Emergency Contact Phone: _____ Emergency Contact Alternate Phone: _____

CONCERNS

What prompted you to seek diagnosis and treatment? Check all that apply.

☐ Sleep Apnea ☐ Snoring ☐ Alternative to CPAP
☐ Mood Disorders ☐ Insomnia ☐ Impaired Cognition

Has your dentist recommeded any dental treatments? _____

Other Dental Concerns? _____

Any Other Concerns? _____

Treatment Will Be Successful When? _____

MEDICAL INSURANCE

Primary Insurance Information

Insurance Company Name: _____ Insurance Phone: _____

Insurance Address: _____ Group Name: _____ Group #: _____

Name of Subscriber: _____ Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child

Subscriber ID #: _____ Subscriber's Employer: _____

Secondary Insurance Information

Insurance Company Name: _____ Insurance Phone: _____

Insurance Address: _____ Group Name: _____ Group #: _____

Name of Subscriber: _____ Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child

Subscriber ID #: _____ Subscriber's Employer: _____

ACCOUNT INFORMATION

Person Financially Responsible for Account: _____

Relation to Patient: _____ Social Security #: _____

Billing Address: _____

Employer: _____ Work Phone: _____ Wireless Phone: _____

FINANCIAL RESPONSIBILTY

I understand the responsibility for payment of dental services provided in this office for myself and 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 inquires as deemed necessary to establish credit with the office, including a formal credit review. I hearby authorize payment of my dental insurance benefits directly to Dr. William E. Williams. I understand my insurance carrier may pay less than the actual bill for services. I understand that I am financially responsible for payment in full of all accounts by signing this agreement.

We allow your insurance company up to 45 days 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 patient, parent,or guardian

_____ Date: _____ Relationship to Patient: _____

Signature of guarantor/responsible party

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

MEDICAL HISTORY

Last Name: _____ First Name: _____ Birthdate: _____

Preferred Pharmacy: _____ Pharmacy's Phone: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

List all medications that you are now taking:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

Are you allergic to any of the following?

Y	N		Y	N		Y	N	
☐	☐	Anesthetic	☐	☐	Ibuprofen	☐	☐	Epinephrine
☐	☐	Aspirin	☐	☐	Latex	☐	☐	Sulfa
☐	☐	Codeine	☐	☐	Penicillin	☐	☐	Prednisone
☐	☐	Other allergies not listed above: _____						

Do you have or have you had any of the following medical conditions?

Y	N		Y	N		Y	N	
☐	☐	Artificial Heart Valve	☐	☐	Kidney Disease	☐	☐	Arthritis
☐	☐	Pacemaker	☐	☐	Sinus Problems	☐	☐	HIV Positive or AIDS
☐	☐	Cancer	☐	☐	Epilepsy	☐	☐	Artificial Joints
☐	☐	Heart Murmur	☐	☐	Psychiatric Treatment	☐	☐	**None of the Above**

Sleep Associated Conditions

☐	☐	Diabetes	☐	☐	Heart Disease	☐	☐	Impaired Cognition
☐	☐	History of Stroke	☐	☐	Mood Disorders	☐	☐	Fatigue
☐	☐	High Blood Pressure	☐	☐	Insomnia			
☐	☐	Other conditions not listed above: _____						

Tobacco use? If so, what kind and how much? _____

Allergic skin reactions to metal jewelry? _____

CONSENT FOR TREATMENT

I understand that the information contained in 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 healthcare provider or agency who may release such information to you. I will notify Dr. William E. Williams of any changes in my health or medication. The undersigned hereby authorizes Dr. William E. Williams to take x-rays, study models, photographs, or any other diagonostic aids deemed appropriate by the doctor to make a thorough diagnosis of the patient's dental needs. Upon such diagnosis, I authorize Dr. William E. Williams 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 records are strictly confidential. Signing this form authorizes us to transfer records to and from another dentist.

Patient/Guardian Signature _____ Date: _____

NOTICE OF PRIVACY PRACTICES William E. Williams, DDS

Patient's Name: _____ Birthdate: _____
Last First MI

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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

Patient/Guardian 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 and a signature was not possible at the time.

☐ The individual refused to sign.

☐ A copy was mailed/emailed with a request for a signature by return mail/email.

☐ Unable to communicate with the patient for the following reason:

_____

☐ Other: _____

Prepared by: _____

Signature: _____ Date: _____