WELCOME TO THE DENTAL OFFICE
of

Letitia M Williams, D.D.S., LLC

206 Conecuh Avenue East
Union Springs, AL 36089
(334) 738-3111
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We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we will be glad to help. We look forward to working with you in enhancing and maintaining your family's dental health.

Date: ____/___/_____

1. PATIENT'S INFORMATION

Name_____ **Social Security #** _____
Last Name First Name MI
Address _____
City _____ **State**_____ **Zip** _____
Home Phone:_____ **Cell Phone:**_____ **E-Mail:** _____
Work Phone:_____
Your preferred method of being contacted: ☐ Home ☐ Cell ☐ Text Message ☐ E-Mail ☐ Work

DOB:____/____/_____ Gender: ____ Female ___ Male

Driver's License #: _____ State: _____

Place of Employment: _____ Occupation: _____

In case of emergency who should we notify:_____

Relationship:_____**Phone Number: _____**

Who can we thank for referring you to us? _____

Reason for Today's Visit? _____

Are you taking any pain medication? ☐ No ☐ Yes What? _____

Do you need to be premedicated? ☐ No ☐ Yes ☐ I don't know
Date of Last Dental visit: ____/____/_____ Former Dentist?: _____

Did the Dentist take x-rays? ☐ No ☐ Yes ☐ I don't know

2. RESPONSIBLE PARTY

Name _____ **Social Security #** _____
Last Name First Name MI

Address _____
City _____ **State** _____ **Zip**_____
DOB: _____ **Gender:** ____ **Female** ___ **Male**
Driver's License # _____ **State:** _____
Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____
Place of Employment_____ _____
E-mail address: _____

3. PERSONAL/GROUP HEALTH INSURANCE

Primary Ins. Comp. _____
Subscriber Name _____ **DOB** ____/_____/_____
Social Security #_____ **Ins. Company:** _____
Group #:_____ **Contract #:**_____
Relationship to insured:_____
Covered by Medicaid: ☐ **No** ☐ **Yes** **Medicaid #:** _____

Secondary Ins. Comp. _____
Subscriber Name _____ **DOB** ____/____/_____
Social Security #_____ **Ins. Company** _____
Group # _____ **Contract #** _____
Relationship to insured:_____

4. AUTHORIZATION

I authorize my insurance company to pay the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of my signature on all submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits.

I understand that I am responsible for all charges whether or not paid by my insurance. ALSO, I UNDERSTAND THAT PAYMENT IS DUE IN FULL AT TIME OF TREATMENT UNLESS PRIOR ARRANGEMENTS HAVE BEEN APPROVED. I accepts the fee charged as a lawful debt and promises to pay said fee including the cost of collection, attorney fees, and court costs if such be necessary, waiving now and forever the right to claim exemption under the constitution and laws of the State of Alabama, or any other state.

Signature: _____ **Date:** ____/____/_____

CASH PATIENTS:

ALL CASH PATIENTS MUST PAY ENTIRE BILL AT THE TIME OF SERVICE.

INSURANCE PATIENTS:

It is important that you be informed that if you are covered by dental or accident insurance, our professional services are rendered and charged to you, not the insurance company! Our services are offered on the basis that full charges will be paid by you. Most insurance coverages only pay a certain portion of the cost of services that may be necessary. In the event that you cannot provide an insurance card or insurance coverage cannot be verified, we must operate on the policy that you are responsible for full payment until your insurance is confirmed. Understand that this office cannot make a totally accurate estimate of the insurance benefits to be paid. Understand that after the insurance company pays there could be a balance remaining which you (the patient) are responsible for.

_____	_____	_____	_____
SIGNATURE OF GUARANTOR	**DATE**	**OFFICE PERSONNEL**	**DATE**

5. MEDICAL HISTORY

Physician's Name: _____ Date of Last Visit ____/____/_____
Have you had any serious illnesses or operation? [ ] No [ ] Yes -If yes, when?_____
Type of operation(s). _____
Have you ever had a blood transfusion? [ ] No [ ] Yes - give dates _____
Are you pregnant? [ ] No [ ] Yes [ ] not sure Nursing A Child? [ ] No [ ] Yes
Are you taking birth control pills? [ ] No [ ] Yes Type _____
ARE YOU TAKING DAILY ASPIRINS? [ ] NO [ ] YES

Please check yes or no in order to indicate if you have or have had any of the following:

[ ] No [ ] Yes Heart Disease	**[ ] No [ ] Yes Heart Murmur**	**[ ] No [ ] Yes Stroke**
[ ] No [ ] Yes Rheumatic fever	**[ ] No [ ] Yes Ulcer**	**[ ] No [ ] Yes Cancer**
[ ] No [ ] Yes Artificial joints	**[ ] No [ ] Yes Arthritis, rheumatism**	**[ ] No [ ] Yes Blood Disease**
[ ] No [ ] Yes High Blood Pressure	**[ ] No [ ] Yes Chemical Dependency**	**[ ] No [ ] Yes Skin Rash**
[ ] No [ ] Yes Chemotherapy	**[ ] No [ ] Yes Liver Disease**	**[ ] No [ ] Yes Headaches**
[ ] No [ ] Yes Mitral valve prolapse	**[ ] No [ ] Yes Hay fever**	**[ ] No [ ] Yes Epilepsy**
[ ] No [ ] Yes Circulatory Problems	**[ ] No [ ] Yes HIV Positive**	**[ ] No [ ] Yes Ulcers**
[ ] No [ ] Yes Glaucoma	**[ ] No [ ] Yes Sinusitis**	**[ ] No [ ] Yes Hemophilia**
[ ] No [ ] Yes Tuberculosis	**[ ] No [ ] Yes Artificial heart valve**	**[ ] No [ ] Yes Jaundice**
[ ] No [ ] Yes Anemia	**[ ] No [ ] Yes Hepatitis**	**[ ] No [ ] Yes Tonsillitis**
[ ] No [ ] Yes Psychiatric Care	**[ ] No [ ] Yes Shortness of breath**	**[ ] No [ ] Yes Pacemaker**
[ ] No [ ] Yes Nervous Problems	**[ ] No [ ] Yes Thyroid Problems**	**[ ] No [ ] Yes Diabetes**
[ ] No [ ] Yes Respiratory Disease	**[ ] No [ ] Yes Abnormal Blood pressure**	**[ ] with Insulin**
[ ] No [ ] Yes Venereal disease: Type _____		**[ ] without Insulin**
[ ] No [ ] Yes Asthma, if yes, do you use an inhaler [ ] No [ ] Yes		

Alergies (including drugs): [ ] No [ ]Yes, Please Indicate types

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Are you sensitive to anesthesia? [ ] No [ ]Yes If yes, please Indicate type:

_____

Medications: [ ] No [ ] Yes, Please Indicate Rx. _____

_____

_____

Patient's Signature:_____ Date: ____/____/_____

Review of Medical History: (*To be completed by staff.)*

Initial	Date	Changes
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____