206 Conecuh Ave. East – Union Springs, AL 36089
334-738-3111 (O) – 334-738-3211 (Fax)

DR. LETITIA M. WILLIAMS
REGISTRATION FORM

(Please Print)

Today's date:	Chart#:

PATIENT INFORMATION

Patient's last name: First: Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Status (circle one) Single / Married/ Child

	Patient Social Security No:	If Child – Pediatrician:	Birth date: / /	Age:	Sex: ❑ M ❑ F

Mailing Address:	City	State Zip Code

Home#: Mobile#:	Occupation:	Employer:	Employer Phone#:

Responsible Adult (if different from patient):	Mailing Address (If different from above):	Phone# (if Different from above): ( )

E-Mail Address: _____ Referred by: _____

Contact by: ❑ E-mail ❑ Home Phone ❑ Text ❑ Other

Other family members seen here:

INSURANCE INFORMATION

Person responsible for bill:	Birth date: / /	Address (If different):	Responsible Party Contact No: ( )

Is this person a patient here? ❑ Yes ❑ No Responsible Party's E-Mail: _____@_____

Occupation:	Employer:	Employer phone no.: ( )

Covered by insurance? ❑ Yes ❑ No

Primary insurance ❑ BlueCross/Blue Shield of Alabama ❑ Delta Dental ❑ Met Life ❑ Viva Medicare

❑ United Healthcare ❑ Cigna ❑ Southland ❑ Medicaid ❑ Other _____

Subscriber's name:	Subscriber's S.S. no.:	Subscriber's DOB: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Contact No. ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Dr. Letitia M. Williams or insurance company to release any information required to process my claims. Our office is HIPAA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

_____ _____

Patient/Guardian signature *Date*

DENTAL HISTORY

Having discomfort at this time? Y or N - What is the discomfort? _____
How long since you have been to a dentist? _____ Did you have x-rays? Y or N
Are your teeth sensitive to: (Circle those that apply) - Heat / Cold / Sweets / Sour / Pressure
Have you ever had your teeth straightened? Y or N - If yes, when? _____ Traditional braces? Y or N
How often are teeth brushed? _____ How often dental floss? _____
Any bleeding gums? _____ Have you ever had gum treatment? _____ ____ When? _____
Do you grind or clench your teeth? _____ Do you hear popping or clicking noises when you chew? _____
Do you have any pain around either of your ears? _____ Any swelling or lumps in your mouth? _____
Do you have any fear of dental treatment? Y or No
How do you feel about the appearance of your teeth? _____

Your Child's Dental Information – Last Dental Appointment _____
(Please check the box(s) that apply)

- ❑ Drinks City Water
- ❑ Sucks Finger
- ❑ Sucks Thumb
- ❑ Sucks Tongue
- ❑ Bites Nails
- ❑ Received office fluoride treatment
- ❑ Fluoride vitamins
- ❑ Fluoridated toothpaste
- ❑ Breastfed, when stopped _____
- ❑ Had/Has Braces
- ❑ Do you brush their teeth?
- ❑ Do you floss their teeth?
- ❑ Get cold sores or fever blisters
- ❑ Inherited any dental conditions

How often are child's teeth brushed? _____ How often does child floss? _____
Has your child ever had a dental injury (bumped or chipped tooth, bruised lips, etc.?) Yes or No – Explain

_____

MEDICAL HISTORY

Do you or have you experienced any of the following? (Please check the box(s) that apply)

- ❑ Free Bleeding
- ❑ Alcohol Use
- ❑ Anemia/Low Blood
- ❑ Artificial Bones/Joints
- ❑ Artificial Valves
- ❑ Asthma w/inhaler
- ❑ Asthma w/o inhaler
- ❑ Cancer
- ❑ Chemotherapy
- ❑ Colitis
- ❑ Congenital Heart Disease
- ❑ Diabetes with insulin
- ❑ Diabetes with pill
- ❑ Emphysema
- ❑ Fever Blisters
- ❑ Glaucoma
- ❑ Headaches
- ❑ Heart Attack
- ❑ Heart Murmur
- ❑ Heart Surgery
- ❑ Hemophilia
- ❑ Hepatitis
- ❑ Herpes
- ❑ High Blood Pressure
- ❑ HIV+/AIDS
- ❑ Kidney Problems
- ❑ Dialysis
- ❑ Liver Disease
- ❑ Lupus
- ❑ Pacemaker
- ❑ Stomach Ulcers
- ❑ Radiation Treatment
- ❑ Seizures
- ❑ Stroke
- ❑ Tuberculosis (TB)
- ❑ Venereal Disease
- ❑ Tobacco Usage

Please List any serious medical condition(s) or surgeries that you have experienced: _____

_____.

Allergies to any of the following? (Check the box(s) that apply:

- ❑ Aspirin
- ❑ Barbiturates
- ❑ Codeine
- ❑ Dental Anesthetics
- ❑ Erythromycin
- ❑ Jewelry/Metals
- ❑ Latex
- ❑ Penicillin
- ❑ Sedatives
- ❑ Sulfa Drugs
- ❑ Tetracycline

Please list any additional drugs/materials that cause allergic reactions not listed above: _____

_____

Please list any medications you are currently taking: _____

_____

What pharmacy do you use? _____ **Phone**#: _____

For Women:

Are you taking birth control pills? ____ Are you pregnant? _____ Week#: _____ Are you nursing? _____

I affirm that the information I have given is correct to the best of my knowledge. All information herein will be held in the strictest confidence and it is my responsibility to inform Dr. Williams and staff of any changes in my medical status. I authorize Dr. Williams and staff to perform the necessary dental services I may need, including x-rays, photographs, study models, or any aids deemed appropriate to make a thorough diagnosis of my/and or the patient's dental needs.

Patient/Guardian Signature: _____ _____ Date: _____

FINANCIAL

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 service 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 remaining balance for which you (the patient or responsible person) **ARE** responsible.

Authorization: I authorize my insurance company to pay the dentist benefits insurance all otherwise payable to me for services rendered. I authorize the dentist to release all the information necessary to ensure benefit payments. I understand that I am responsible for all the expenses paid by my insurance company or not. **ALSO, I UNDERSTAND THAT PAYMENT IS DUE IN FULL AT TIME OF TREATMENT UNLESS PRIOR ARRANGEMENTS HAVE BEEN APPROVED**. I accept the fee charged as lawful debt and promise to pay said fee including the cost of collection, fees of lawyers and Court cost if such be necessary, waiving now and forever the right to claim an exemption under the Constitution and the laws and the State of Alabama, or any other state.

Signature: _____ Date: _____