Williams and Williams Facial and Oral Surgery: Patient Information

NAME: First, MI, Last	Patient Employer
ADDRESS:	Address
CITY STATE ZIP	City State Zip
CONTACT NUMBER	Occupation
E-MAIL	**Emergency Contact**
DOB AGE SEX ☐ M ☐ F MARTIAL STATUS	Phone Relationship to Patient
SSN # DRIVERS LICENSE #	Medical Physician
Referring Dentist or Individual	Phone #

1. Are you in good health?.....YES / NO
2. Has there been any change in your general health in the last year?.....YES / NO
3. Are you now under a physician's care for a particular problem?.....YES / NO
4. Have you had any serious illnesses, operations or hospitalizations?.....YES / NO
5. Have you ever had excessive bleeding requiring special treatment?.....YES / NO
6. Are you subject to fainting, dizziness, convulsions, seizures, or epilepsy? .....YES / NO
7. Have you ever had Asthma, Emphysema, Tuberculosis, Pneumonia or difficulty breathing.....YES / NO
8. Have you ever had any of the following:
   a) Heart problem.....YES / NO
   b) Stroke.....YES / NO
   c) Rheumatic Fever or Heart Murmur.....YES / NO
   d) Liver disease, Hepatitis, Jaundice.....YES / NO
   e) Kidney disease.....YES / NO
   f) High or low blood pressure.....YES / NO
   g) Diabetes.....YES / NO
   h) Anemia.....YES / NO
   i) Stomach ulcers.....YES / NO
   j) Thyroid disease (goiter).....YES / NO
   k) Glaucoma.....YES / NO
   l) Implants placed anywhere in your body (heart valve, hip, knee).....YES / NO
   m) Any disease, drugs or transplant operation that has depressed your immune system.....YES / NO
   n) AIDS/ ARC/ HIV.....YES / NO
9. Are you wearing contact lenses.....YES / NO
10. Are you using or taking any of the following:
    a) Antibiotics.....YES / NO
    b) Anticoagulants (Plavix, Coumadin).....YES / NO
    c) High blood pressure medication.....YES / NO
    d) Steroids (Cortisone).....YES / NO
    e) Tranquilizers (Valium) .....YES / NO
    g) Digitails, Inderal, Nitroglycerine or other heart medicine.....YES / NO
    h) Aspirin.....YES / NO
    i) Osteoporosis medications (Fosamax, Actonel, Bonvia).....YES / NO
    j) **WOMEN;** Birth control pills.....YES / NO
11. Please list all **medication allergies**:
12. Do you smoke or use smokeless tobacco products?.....YES / NO
13. Have you ever sought treatment for drug abuse or alcoholism?.....YES / NO
14. Do you have other medical conditions or concerns that the doctor should know about?.....YES / NO
15. Have you ever been treated for or diagnosed with TMJ (jaw joint) pain, noise or limited function?.....YES / NO
16. Do you currently have TMJ problems?.....YES / NO
17. Are you allergic to eggs or sulfites?.....YES / NO
18. Are you allergic to Latex?.....YES / NO
19. **WOMEN:** Are you pregnant or planning pregnancy?.....YES / NO

_____ RDA's Initials

_____ Doctor's Initials

I understand the information I provide on this form is essential to determine my dental needs and the provision of treatment. I understand that if any change occurs in my health I will report it to the office as soon as possible. I have read and understood these questions and answered them all truthfully and to the best of my ability, and I have had an opportunity to discuss my health history with the doctor.

I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY CHARGES INCURRED TODAY.

_____ Signature of responsible party/Legal guardian

_____ Date

Medication Form

In order to serve you to the best of our abilities, please list all medications you are currently taking:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Past Surgical History

Please list all surgical procedures performed

Procedure:	Estimated Date:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

_____ _____

Patient signature Date

If we are filling Insurance on your behalf, please fill out the following

Williams & Williams Facial and Oral Surgery

Dr. Todd A. Williams

Consent for Insurance Release

We are committed to protecting your confidentiality and right to privacy. In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), we are required to obtain consent from you prior to releasing any information to your insurance agency. If you desire for us to prepare your insurance claim and ready it for mailing for you, we need your consent. This will also permit us to respond to requests by your insurance company for explanation of treatment necessity or radiograph duplication and forwarding. Both are common requests by insurance companies necessary to complete claim processing and reimbursement.

Please understand this is no way allows for us to release any information regarding you or your treatment to any contractors, employers, government agencies, or any other third parties, except when stipulated by law. This is a strict statement regarding provision of information to your insurance company for processing your claim for reimbursement.

Dental Insurance Information

Primary Insurance _____

Address _____

City _____ State _____ Zip _____

Phone # _____

Insured Name _____

Insured SS # _____ Group # _____

Insured DOB _____ Insured ID # _____

Employer _____

Insured's relationship to Patient _____

I hereby authorize payment of benefits to Dr. Todd A. Williams for services performed that otherwise would have been payable to me. I understand that I am financially responsible for charges not covered by this assignment, including any legal fees, if incurred, to collect any outstanding balance.

_____ _____

Patient Signature/Legal guardian Date

Williams & Williams Facial and Oral Surgery

Dr. Todd A. Williams

Consent for Disclosure of Health Care Information

Patient's name: _____ Date of Birth: _____

SSN #: _____

Doctor's Name: Dr. Todd A. Williams

Practice Name: Williams and Williams Facial and Oral Surgery

My personal health information is private and confidential. I understand that my doctor and his staff work very hard to protect my privacy and preserve the confidentiality of my person health information.

I understand that my doctor and his staff may use and disclose my personal health information to help provide health care to me, to handle billing and payment, and to take care of other health care operations. There will be no other uses and disclosures of this information unless I permit it. However, I understand that sometimes the law may require the release of this information without my permission,

I can ask my doctor to limit how my personal health information is used or disclosed to carry out treatment, payment, or health care operations. I understand that my doctor does not have to agree to my request, I understand that my doctor and his staff would follow the agreed limits.

I may cancel this consent at any time by doing one of the following:

1) Signing and dating a form that my doctor or his staff can give me a called "Revocation of Consent for use and Disclosure of Health Information"; or
2) Writing, signing and dating a letter to my doctor directly. If I write a letter, it must say that I want to cancel my consent to authorize the use and disclosure of my personal health information for treatment, payment and healthcare operations.

If I cancel this consent, my doctor and his staff do not have to provide any further health care services to me.

My doctor has a detailed document called the "Notice of Privacy Practices." It contains more information about the policies and practices protecting my privacy. I understand that I have the right to read the "Notice" before signing this agreement. My doctor may update this "Notice". If I ask, my doctor and his staff will provide me with the most current "Notice" and the current "Notice" will always be posted at my doctor's office.

My signature below indicates that I have been given the chance to review a current copy of my doctor's "Notice of Privacy Practices". My signature means that I agree to allow my doctor to use and disclose my personal health information to carry out treatment, payment and healthcare operations.

_____ _____

Patient/Legal Guardian Signature Date

_____

Relationship to Patient

Williams & Williams Facial and Oral Surgery

Dr. Todd A. Williams

Patient Disclosure Instructions

In general, the HIPAA rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

☐ Home/Cell telephone _____

☐ O.K to leave message with detailed information

☐ Leave message with call back number only

☐ Written Communication

☐ O.K to mail to my home address

☐ O.K to mail to my work/office address

☐ O.K to fax number indicated

☐ O.K to text to cell phone

☐ Work telephone _____

☐ Other (fax/cell, etc.) _____

_____

☐ O.K to leave message with detailed information

☐ Leave message with call back number only

I allow you to give my clinical information to or answer any questions from (check ALL that apply):

☐ Spouse

☐ Parent

☐ Child

☐ Other (specify): _____

☐ None

_____ _____

Patient/Legal Guardian Signature Date

_____ _____

Print name Date