

GENERAL HEALTH SCREENING

Please circle "Yes" or "No" for each question.

Have you been experiencing ANY symptoms of Cold, Flu, or COVID? If yes, please describe:	Y	N
Have you been advised within the last three weeks to quarantine due to exposure of an individual that has tested positive for COVID-19?	Y	N
Are you currently waiting on the results of a COVID-19 test? If yes, when were you tested?	Y	N
Have you been diagnosed with COVID-19? If yes, when?	Y	N

Signature _____ Date _____

Williams Oral & Maxillofacial Surgery, Prof LLC

PATIENT INFORMATION

First Name _____ M.I. _____ Last Name _____

Nickname _____ Dentist _____ Referring Doctor _____

Mailing address _____ City _____ State _____ Zip _____

Cell Phone _____ Home Phone (if different) _____

Birth Date ____/____/____ Sex: M / F Social Security number _____

Marital status: Married / Single / Widowed / Divorced Has a family member been a patient of our practice? Y / N

Employer / School _____ Fulltime / Part time Work Phone _____

Personal email _____

Emergency contact _____ Relationship _____ Phone _____

PERSON RESPONSIBLE FOR PAYMENT / MUST BE FILLED OUT BY PARENT OR GUARDIAN IF PATIENT IS UNDER 18 YEARS OLD

Self (if self, skip this section) Spouse Father Mother Other _____

First Name _____ Last Name _____ Nickname _____

Mailing address _____ City _____ State _____ Zip _____

Home Phone () _____ Cell Phone () _____

Birth Date ____/____/____ Sex: M / F Social Security number _____

Marital Status _____ Email _____

PRIMARY INSURANCE – PLEASE PROVIDE CARD(S) AT FRONT DESK

Dental Insurance: _____

Member ID# _____

Group# _____ EDI/Payer ID: _____

Claims mailing address: _____

Policy holder name: _____

Relationship to patient: _____

Birth date: ____/____/____

Policy holder's mailing address: _____

Medical Insurance: _____

Member ID# _____

Group# _____ EDI/Payer ID: _____

Claims mailing address: _____

Policy holder name: _____

Relationship to patient: _____

Birth date: ____/____/____

Policy holder's mailing address: _____

For patients 18 years old and over:

I authorize you to speak to: _____ Relationship: _____

I authorize you to speak to: _____ Relationship: _____

Williams Oral & Maxillofacial Surgery, Prof LLC.

HEALTH HISTORY

Patient Name _____ Birth Date ___/___/___ Age ____ Today's Date _____

Please complete the health history so that we may provide the best possible care; the doctor will discuss the history with you prior to beginning treatment.

GENERAL INFORMATION

Sex: M / F Height _____ Weight _____ Are you in good health? Y / N

Reason for today's office visit? _____

Are you now under a physician's care for a particular problem? If so, describe: _____

Physician name and telephone # _____ Date of last physical exam _____

Has there been any change in your general health in the past year? If so, describe: _____

Have you ever had any serious illness? If so, describe: _____

Have you ever been hospitalized or had any surgery or anesthesia? If so, describe: _____

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? Y / N

A) PLEASE CIRCLE THE NUMBER IF THE ANSWER IS "YES"

1. Can you take pills?
2. Do you have pain, clicking or popping of the jaw joint, or difficulty opening mouth?
3. Do you grind or clench your teeth?
4. Have you had any serious problems associated with previous dental treatment?
5. Have you or an immediate family member had any problem associated with anesthesia?
6. Do you smoke or chew tobacco?
How much? _____
For how long? _____
7. Have you ever quit smoking? _____
How long ago? _____
8. Is there any past history of alcohol or chemical dependency?
9. Is there any emotional or psychiatric illness that may affect the care we provide?
10. Do you wish to talk to the doctor privately about anything?

B) FOR FEMALE PATIENTS ONLY

1. Are you pregnant, or is there any chance you might be pregnant? _____ How many weeks along? _____
2. Are you nursing? _____

If you are using Oral Contraceptives, it is important that you understand that antibiotics and some other medications may interfere with the effectiveness of oral contraceptives. You may need to use an additional form of birth control for one cycle of birth control pills after a course of antibiotics or other medication is completed. Please consult with your physician.

Williams Oral & Maxillofacial Surgery, Prof LLC.

C) DO YOU HAVE OR HAVE YOU EVER HAD: PLEASE CIRCLE THE NUMBER IF THE ANSWER IS "YES"

- | | |
|--|---|
| 1. Cardiovascular disease?
(heart attack, coronary artery disease, angina, chest pain, irregular heart rate or palpitations, congenital heart disease, rheumatic heart disease, murmur) | 18. Arthritis? |
| 2. High blood pressure? | 19. Stomach ulcers or acid reflux? (GERD) |
| 3. Stroke? | 20. Other GI disease? |
| 4. Heart surgery? (bypass or stent) | 21. Glaucoma? |
| 5. Pacemaker? | 22. Osteoporosis? |
| 6. Respiratory disease?
(asthma, emphysema, COPD, chronic cough, bronchitis) | 23. Joint replacements? |
| 7. Epilepsy? | 24. Cancer? |
| 8. Seizures? | 25. Radiation therapy? |
| 9. Brain Injury? | 26. Chemotherapy? |
| 10. Fainting / dizziness? | 27. Sinus and/or nasal problems? |
| 11. Bleeding disorder / anemia? | 28. Seasonal allergies? |
| 12. Blood transfusion? | 29. Snore? |
| 13. Bruise or bleed easily? | 30. Sleep apnea? |
| 14. Liver disease?
(jaundice, hepatitis) | 31. Fibromyalgia? |
| 15. Kidney disease? | 32. Psychiatric illness or mood disorder? |
| 16. Diabetes? | 33. Disease or medication that has depressed
your immune system? |
| 17. Thyroid disease? | 34. Organ transplant? |
| | 35. Delay in healing? |
| | 36. Do you have any other disease, condition or problem not
listed above that you think the doctor should know
about? |

D) ARE YOU ALLERGIC TO OR HAVE YOU HAD AN ADVERSE REACTION TO: PLEASE CIRCLE THE NUMBER IF THE ANSWER IS "YES"

- | | |
|---------------------------------------|---|
| 1. Local anesthesia (Novocain, etc.)? | 8. Latex or rubber products? |
| 2. Penicillin? | 9. Chemicals or jewelry (rash or sensitivity)? |
| 3. Antibiotics? | 10. Food products? Soy? Eggs? |
| 4. Sedatives, barbiturates? | 11. Have you ever been advised to not take a medication? |
| 5. Aspirin? | 12. Other allergies or reactions? If so, please list:

_____ |
| 6. Ibuprofen? | |
| 7. Codeine or other pain killers? | |

E) ARE YOU TAKING ANY OF THE FOLLOWING: PLEASE CIRCLE THE NUMBER IF THE ANSWER IS "YES"

- | | |
|---|---|
| 1. Antibiotics? | 9. Insulin or oral anti-diabetic drugs? |
| 2. Anticoagulants or blood thinners (Coumadin, Plavix, etc.)? | 10. Have you ever taken bisophosphonates,
antiangiogenic, antiresorptive bone density medications?
(Reclast, Fosamax, Actonel, Boniva, Aredia, Zometa,
Prolia, Avastin, Sutent) |
| 3. Aspirin? | 11. Other Medications: (please provide list)

_____ |
| 4. Ibuprofen? | |
| 5. Steroids (cortisone, prednisone, etc.)? | |
| 6. Sleep Aids / Trainquizers? | |
| 7. Antidepressants? | |
| 8. Narcotics? | |



I understand the importance of a truthful and complete health history to assist the doctor in providing the best possible care. To the best of my knowledge, the information given on these three pages is true and correct.

Patient / Legal Guardian Signature

Date

Williams Oral & Maxillofacial Surgery, Prof LLC

PATIENT NAME: _____

Financial Responsibility

I understand and agree to the following:

- I am responsible for any and all charges on this account.
- Full payment is due on the day of service, unless other arrangements were made before today.
- Insurance:
 - Any payment made by me on the day of my appointment is only a down-payment. My insurance payment may be significantly less than the remaining balance on my account. I understand that I will be billed for any remaining balance on my account.
 - IV sedation/general anesthesia: Insurance companies do not cover sedation for simple, uncomplicated tooth extractions.
 - ConeBeam CT scans: Dr. Williams may require a CBCT scan for my treatment. These scans are often not covered by any insurance. I understand I am responsible for this charge.
 - Bone Grafts: Sometimes after a tooth is extracted, a bone graft is needed to preserve the site for a future implant. These are often not covered by dental insurance when done at the time of extraction. If Dr. Williams and I decide a bone graft is needed, I understand I may be responsible for the full amount.
 - Medicare does not cover tooth extractions or sedation for tooth extractions. I understand that I am responsible for these charges.
 - I understand that I am responsible for any and all charges not covered by my insurance. Balances after insurance must be paid off by six months unless other arrangements have been made.
 - I authorize direct payment to Williams Oral and Maxillofacial Surgery Prof LLC by my insurance company. A copy of this original may be used in place of the original.
- If no attempt is made to pay an account balance more than 60 days old, my account will be assessed a late fee of \$35.00 per month, every month, until the account is paid in full. Alternatively, a collection agency may be utilized. I understand it is my responsibility to inform this office of any change of address.



Signature: _____ Date: _____

Acknowledgement of Receipt of Privacy Practices

I have received a copy of this office's Notice of Privacy Practices.

Signature: _____ Date: _____



Printed Name: _____ (Please initial if you refuse to sign _____)