LASER PERIODONTICS & IMPLANT DENTISTRY

BENJAMIN D. WILLIAMS, D.M.D.

PATIENT REGISTRATION

First Name: _____ Last Name: _____ Middle Initial: ____

Patient Is: ☐ Policy Holder Preferred Name: _____

☐ Responsible Party

Responsible Party (if someone other than the patient)

First Name: _____ Last Name: _____ Middle Initial: ____

Address: _____

City, State, Zip: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Mobile: _____

Birth Date: _____ Soc Sec: _____ Drivers Lic: _____

Employer Name/Phone: _____

◯ Responsible Party is also a Dental Insurance Policy Holder for Patient

Patient Information

Address: _____

City: _____ State / Zip: _____ _____ Mobile: _____

Home Phone: _____ Work Phone: _____

Sex: ◯ Male ◯ Female Marital Status: ◯ Married ◯ Single ◯ Divorced ◯ Separated ◯ Widowed

Birth Date: _____ Age: _____ Soc. Sec: _____ Drivers Lic: _____

E-mail: _____ ☐ I would like to receive correspondences via e-mail.

Section 2 Section 3

Employer Name: _____

Employer Phone: _____

General Dentist: _____

Pref. Pharmacy/Phone: _____

Spouse Name/Phone: _____

Spouse Employer/Phone: _____

I was referred by: _____

My Emergency Contact is: _____

Emerg. Phone#: _____

May we reach you by text? ◯ Yes ◯ No

Student Status: ◯ Full Time ◯ Part Time

My Employment Status:

◯ Full Time ◯ Part Time ◯ Retired

Primary Dental Insurance Information

Name of Insured: _____ Relationship to Insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insured ID number: _____ Insured Birth Date: _____ Group Number _____

Employer: _____

Address: _____

Address 2: _____

City,State,Zip: _____

Ins. Company: _____

Address: _____

Address 2: _____

City,State,Zip: _____

Rem. Benefits: _____ Rem. Deduct: _____

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or practitioners. I agree to be responsible for payment of all services rendered on my behalf or my dependents. In consideration of the services rendered or to be rendered, the undersigned agree(s) to pay for all services rendered in a manner acceptable with the office. In the event of default on payment, the undersigned agrees to pay all costs of collection, including attorney fees. The undersigned hereby waives all rights and claims of exemptions under state and federal laws.

_____ _____

Signature of Patient or Legal Guardian Date

Benjamin D. Williams, D.M.D.

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

On a scale of 1-10 (10 being the highest), how important is your dental health to you? _____

On a scale of 1-10 (10 being the highest), where do you rate your current dental health? _____

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: _____

Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____

Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____

Are you taking any medications, pills, or drugs? ◯ Yes ◯ No **If yes, please complete our **Medication List** form**

Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No _____

Are you on a special diet? ◯ Yes ◯ No

Do you use tobacco? ◯ Yes ◯ No

Do you use controlled substances? ◯ Yes ◯ No

Women: Are you

Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs

☐ Other If yes, please explain: _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive ◯ Yes ◯ No	Cortisone Medicine ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	High Cholesterol ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Breathing Problem ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Genital Herpes ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Osteoporosis ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Pacemaker ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Convulsions ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No
			Yellow Jaundice ◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No _____

Comments: _____

_____

_____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

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Medication List

If you are taking any medications, please complete this form.

My Name is _____

My Health Care Provider's Name is _____

My Health Care Provider's Phone Number is _____ _____

I am currently taking the following medications:

Medication	When I take it	Dose	Other Instructions

1715 Golden Springs Rd • Anniston, Alabama 36207 • Ph. 256.231.0077 • Fax 256.231.0866

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Dental Benefit Information Form

Thank you for taking time to acquire this information from your Dental Benefits Administrator. Over time, we have found the insured person is able to secure more information from their insurance company. Our goal is to assist you in obtaining your reimbursement from your insurance company as quickly as possible. A member of our team will help you understand the information you have gathered and the role it will play in going forward with your recommended treatment plan.

Please follow the format and instructions below. If you have any difficulty, please call our office at 256-231-0077 and one of our team members will gladly assist you.

1. **Call the phone number on the back of your dental insurance card.** If you don't have a card (some companies do not issue cards for dental) or a benefits booklet, call your Human Resources officer and they should be able to provide that phone number.

2. Follow the prompts or tell the customer service representative that you are calling to obtain **dental eligibility and benefit information.**

3. **Ask for the following. Please record the answers below:**

Am I currently eligible for dental coverage? Yes or No _____

What is my maximum for the calendar year? $ _____

How much is remaining of my yearly maximum? $ _____

What is my yearly deductible? $ _____

Has my deductible been met? Yes or No/Amount met $ _____

Do I have coverage for Periodontal Care? Yes or No _____

- If yes, what is the **Frequency & Percentage** covered for the following service codes:

Code	Freq	%	Code	Freq	%
D4910			**D4341**		
D4260			**D4271**		
D6010			**D4273**		
D7210			**D4263**		
D7953			**D4266**		

Again, thank you for your efforts in securing this information. Please return this form with your other patient registration information and we will be prepared for your visit with us. We look forward to serving you in the near future.

Dr. Benjamin Williams & Team