William L. Edwards Dentistry

201 E. 8th St., Rome, GA 30161 | Phone: 706-235-8687 | williamedwardsrome.com

To help us meet all your health care needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us and we will be happy to help.

Name _____ Date _____

SSN _____ DOB _____

Address _____ City _____ State _____ ZIP _____

Phone _____ Alt. Phone _____ Email _____

☐ Minor ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

If the patient is student, fill out the next line

School _____ City/state _____ ☐ Part Time ☐ Full Time

Patient or parent/guardian's employer _____ Phone _____

Address _____ City _____ State _____ ZIP _____

Spouse or parent/guardian _____ Phone _____

Emergency contact _____ Phone _____

Did someone refer you? _____

RESPONSIBLE PARTY

Person responsible for this account _____ Relationship _____

Address _____ City _____ State _____ ZIP _____

Phone _____ Alt. Phone _____ Email _____

Driver's License number _____ DOB _____

Employer _____ Work Phone _____ SSN _____

Is this person a patient in our office? ☐ Yes ☐ No

We offer the following methods of payment. Please check the option you prefer. Payment is required at each appointment.

☐ Cash ☐ Check ☐ Credit Card ☐ I wish to discuss the office's payment policy

INSURANCE INFORMATION

Name of insured | Relationship

SSN | DOB

Employer | Work Phone

Address | City | State | ZIP

Insurance Company | Group # | Policy #

Deductible amount | Amount used | Annual benefit

Do you have additional insurance? ☐ Yes ☐ No If yes, complete the following:

Name of insured | Relationship

SSN | DOB

Employer | Work Phone

Address | City | State | ZIP

Insurance Company | Group # | Policy #

Deductible amount | Amount used | Annual benefit

PATIENT DENTAL HISTORY

Previous Dentist | Date of last exam

	Yes	No
1. Do your gums bleed while brushing or floss-	☐	☐
2. Are your teeth sensitive to heat or cold?	☐	☐
3. Are your teeth sensitive to sour liquids/foods?	☐	☐
4. Do you feel pain to any of your teeth?	☐	☐
5. Do you have any sores or lumps in your mouth?	☐	☐
6. Have you had any head, neck or jaw injuries?	☐	☐
7. Have you ever experienced any of the following in your jaw?		
Clicking	☐	☐
Pain (joint, ear, side of face)	☐	☐
Difficulty in opening or closing	☐	☐
Difficulty in chewing	☐	☐

	Yes	No
8. Do you have frequent headaches?	☐	☐
9. Do you clench or grind your teeth?	☐	☐
10. Do you bite your lips or cheeks frequently?	☐	☐
11. Have you ever had any difficult extractions?	☐	☐
12. Have you ever had any prolonged bleeding following extraction?	☐	☐
13. Have you had any orthodontic treatment?	☐	☐
14. Do you wear dentures or partials?	☐	☐
If yes, date of placement _____		
15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	☐	☐
16. Do you like your smile?	☐	☐

PATIENT MEDICAL HISTORY

Physician _____ Phone _____ Date of last exam _____

	Yes	No
1. Are you under medical treatment now?	☐	☐
2. Have you been hospitalized for any surgical operation or serious illness in the last 5 years?	☐	☐
If yes, please explain _____		
3. Are you taking any medication(s) including non-prescription medicine?	☐	☐
If yes, what medication(s)? _____		
4. Have you ever taken Fen-Phen/Redux?	☐	☐
5. Have you ever taken Fosamax, Boniva, Actonel or any cancer medications with bisphosphonates?	☐	☐
6. Have you taken Viagra, Revatio, Cialis or Levitra in the past 24 hours?	☐	☐
7. Do you use tobacco?	☐	☐
8. Do you use controlled substances?	☐	☐
9. Are you wearing contact lenses?	☐	☐

10. Are you allergic to or had any reactions to the following?	Yes	No
Penicillin or any antibiotics	☐	☐
Sulfa drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Any metals (e.g. nickel, mercury, etc.)	☐	☐
Latex rubber	☐	☐
Other _____	☐	☐
11. Do you have a persistent cough or throat clearing not associated with a known illness?	☐	☐
12. For women		
Are you pregnant or think you may be?	☐	☐
Are you nursing?	☐	☐
Are you taking oral contraceptives?	☐	☐

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

	Yes	No
High blood pressure	☐	☐
Heart attack	☐	☐
Rheumatic fever	☐	☐
Swollen ankles	☐	☐
Fainting/seizures	☐	☐
Asthma	☐	☐
Low blood pressure	☐	☐
Epilepsy/convulsions	☐	☐
Leukemia	☐	☐
Diabetes (Type I)	☐	☐
Diabetes (Type II)	☐	☐
Kidney disease	☐	☐
AIDS or HIV infection	☐	☐
Thyroid problem	☐	☐

	Yes	No
Heart disease	☐	☐
Cardiac pacemaker	☐	☐
Heart murmur	☐	☐
Angina	☐	☐
Frequently tired	☐	☐
Anemia	☐	☐
Emphysema	☐	☐
Cancer	☐	☐
Arthritis	☐	☐
Joint replacement	☐	☐
Date & place _____		
Hepatitis/jaundice	☐	☐
STDs	☐	☐

	Yes	No
Stomach troubles/ulcers	☐	☐
Chest pains	☐	☐
Easily winded	☐	☐
Stroke	☐	☐
Hay fever/allergies	☐	☐
Tuberculosis	☐	☐
Radiation therapy	☐	☐
Glaucoma	☐	☐
Recent weight loss	☐	☐
Liver disease	☐	☐
Heart trouble	☐	☐
Respiratory problems	☐	☐
Mitral valve prolapse	☐	☐
Other _____	☐	☐

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 health practitioners. I authorize my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependants.

X _____

Signature of patient (or parent/guardian if minor)

OFFICE POLICY

APPOINTMENT POLICY: As a courtesy, our office makes every effort to verify your appointments. If at any time you need to cancel an appointment, please call our office and if it is after normal business hours please leave a message on the answering machine. However, adequate notice for any appointment is necessary for us to be able to offer valuable doctor or hygiene time to another patient. Therefore, missing an appointment or cancellation of an appointment with less than 24 hour notice is subject to a $25 cancellation charge.

INSURED PATIENTS: On your first visit, or if you have a new insurance carrier, please provide us with the proper information, i.e. insurance card and drivers license. For your convenience, we will process your insurance claim the day of your visit. You are responsible for the timely payment of your account within 90 days regardless of insurance coverage. It is our policy to collect your portion along with deductibles on the day of treatment. There may be an addition balance after insurance pays due to usual and customary fees. Insurance is a contract between you and your insurance company. We are not a party to this contract. Please be familiar with your policy regarding deductibles, co-payments, covered charges, secondary insurance carriers, etc. Legally we cannot become involved in any dispute, other than to provide factual information as necessary.

FINANCIAL POLICY: Payment is expected on the day of treatment. For major treatment, if financial arrangements are needed, they must be made prior to the start of treatment. We accept Visa, Mastercard, Discover Card, Care Credit, personal checks and cash. Any account which has an outstanding balance over 60 days and no payment arrangements made will be charged a professional service fee of 2.5 percent and will be responsible for any additional charges which may occur if the account is turned over to a collection agency. I understand that if my account balance is transferred to an outside collection agency that a 25 percent processing fee will be added.

The undersigned understands and agrees to a credit bureau report if credit is required.

I hereby authorize payment directly to William L. Edwards Dentistry of the group benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment and I understand that my dental insurance carrier may pay less than the actual bill for services. I hereby authorize William L. Edwards Dentistry to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care.

_____

Patient Name

X _____

Signature of responsible party

_____

Date

PATIENT DISCLOSURE INSTRUCTIONS

In general, the HIPAA privacy 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.

☐ Home telephone _____

- ☐ OK to leave message with detailed information
- ☐ Leave message with call-back number only

☐ Work telephone _____

- ☐ OK to leave message with detailed information
- ☐ Leave message with call-back number only

☐ Written communication

- ☐ OK to mail to my home address
- ☐ OK to mail my work/office address
- ☐ Ok to fax to number indicated

☐ Other _____

_____

_____

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

- ☐ Spouse
- ☐ Parent
- ☐ Child
- ☐ Other (specify) _____
- ☐ None

_____ _____

Patient Name | Date of Birth

X _____ _____

Patient Signature | Date