Thomas Williams D.M.D.

Cosmetic & General Dentistry

609 Main Street PO Box 327
Sparkill, New York 10976

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******Important Message******

If you are using a GPS system to our office, please use the following address:
609 Washington Street, Sparkill, NY

We would like to say thank you for choosing us for your dental care and we welcome you to our practice.

Our mission is to provide our patients with the highest quality dental care in a relaxed and caring environment. We strive to educate our patients in their treatment. Our desire is to build long term relationships that promote optimum dental health, which impacts our patients overall well being.

Attached you will find our patient information forms that you may complete at your convenience. You may fill them in on the website but you will need to print them as HIPPA restrictions do not permit saving them electronically. Additionally, you may elect to print the forms and fill them in by hand.

Please bring these forms with you along with your insurance card if applicable.

We are happy to welcome you and we look forward to meeting you.

Sincerely,

Thomas Williams D.M.D. and the Entire Staff

Dedicated Dental Services P.C.
Patient Information Sheet

Patient: (Mr., Mrs., Ms.) First Name: _____ Middle Initial:_____ Last Name:_____
Sex: Male○ Female○ Date Of Birth:_____ Age: _____ Social Security Number: _____
Billing Address: _____
City: _____ State: _____ Zip: _____
Home #: (_____) _____ Business #: (_____) _____Cell #_____
Physician:_____ Phone #: _____
Referred By: _____
e-mail Address: _____

Person Responsible for your account? Relation:○ Self ○Spouse ○Mother ○Father ○Other_____
Name: _____ Social Security: _____ Home Tel: (_____)_____
Street: _____ City: _____ State: _____ Zip: _____
Employer: _____ Telephone: _____

Employer Information:
Name:_____ Telephone # : (_____)_____
Street: _____ City: _____ State: _____ Zip: _____
Plan Name: _____

Dental Insurance Company: *Primary Insurance Carrier*
Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: (_____) _____
Group Name: _____
Group # : _____ Local # : _____

Insured Party:
Name: _____
First MI Last
Relation to Insured: ○Self ○Spouse ○Child ○Other
Sex: Male Female Date of Birth: _____
Street: _____
City : _____State: _____ Zip: _____
Phone: (_____)_____
Social Security # : _____ I.D. # : _____

Employer Information:
Name: _____ Telephone # : (_____)_____
Street: _____ City: _____ State: _____
Plan Name: _____

Dental Insurance Company: *Secondary Insurance Carrier (If Applicable)*
Name: _____
Address: _____
City: _____ State: _____ Zip:_____
Phone: (_____)_____
Group # : _____ Local # : _____
Group Name: _____

Insured Party:
Name:_____
First MI Last
Relation to Insured:○Self ○Spouse ○Child ○Other
Sex: Male Female Date of Birth: _____
Street: _____
City: _____ State: _____ Zip: _____
Phone: (_____)_____
Social Security # : _____ I.D. # : _____

Fees And Payments:
We are committed to providing you the best possible care. Our fees reflect our professional commitment to excellence. We make every effort to keep down the cost of your dental care. You can help by paying upon the completion of each visit. For more extensive treatment a financial plan can be custom designed that accommodates your course of treatment. An estimate of the charge(s) for any procedure or surgery you may require will be given to you upon request. If you have dental insurance we will be glad to fill out the proper forms; however, please complete the identifying information on this form.
Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some insurance companies pay fixed allowances for certain procedures and others pay a percentage of charges. It is your responsibility to pay any and all balances.
The signature below is my authorization for the release of information necessary to process my claim.

Signature: _____ Date: _____

STOP ----- PLEASE RETURN THIS FRONT PAGE TO THE RECEPTIONIST BEFORE PROCEEDING WITH THE NEXT 2 PAGES

 Name: _____

-Health History-

To our patients:

Although dentists primarily treat the area in and around the 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 care you will be receiving. Thank you for answering the following questions. Your answers are for our records only and will be considered confidential.

Reason for today's office visit: _____

_____

10. Are you in good health? ---------- Yes ○ No ○
11. Have there been any changes in your general health in the past year? ---------- Yes ○ No ○
12. Are you under the care of a physician?---------- Date of last visit: _____ Yes ○ No ○
    If so, for what are you being treated? _____
13. Have you had any illness, operation or been hospitalized in the past five years? ---------- Yes ○ No ○
14. Do you have any unhealed injuries, or inflamed areas in or around your mouth, growths or sore spots in your mouth?-------- If so, describe where _____ Yes ○ No ○
15. Do you have a prosthetic joint? ---------- If so, describe where_____ Yes ○ No ○

	Have You Had Or Do You Currently Have------	Yes	No	Notes		**Have You Had Or Do You Currently Have------**	Yes	No	Notes
16.	Rheumatic fever?	○	○		43.	Gallbladder trouble?	○	○	
17.	Damaged heart valves?	○	○		44.	Fainting spells?	○	○	
18.	Mitral valve prolapse?	○	○		45.	Convulsions / epilepsy?	○	○	
19.	Heart murmur?	○	○		46.	Stroke?	○	○	
20.	High blood pressure?	○	○		47.	Thyroid trouble?	○	○	
21.	Low blood pressure?	○	○		48.	Diabetes?	○	○	
22.	Chest pain / angina?	○	○		49.	Low blood sugar?	○	○	
23.	Heart attack(s)?	○	○		50.	Kidney trouble?	○	○	
24.	Irregular heart beat?	○	○		51.	Are you on dialysis?	○	○	
25.	Cardiac pacemaker?	○	○		52.	Arthritis / joint disease?	○	○	
26.	Heart surgery?	○	○		53.	Stomach ulcers?	○	○	
27.	Bronchitis, chronic cough?	○	○		54.	Contagious diseases?	○	○	
28.	Asthma?	○	○		55.	Sexually transmitted Disease?	○	○	
29.	Hayfever / sinus problems?	○	○		56.	Immunosuppressed?	○	○	
30.	Tuberculosis?	○	○		57.	Delay in healing?	○	○	
31.	Emphysema?	○	○		58.	Tumor(s) or growth(s)?	○	○	
32.	Difficulty breathing?	○	○		59.	X-ray Tx. / chemotherapy?	○	○	
33.	Any other lung trouble?	○	○		60.	Chronic fatigue/Night Sweats?	○	○	
34.	Do you smoke?	○	○		61.	Are you on a diet?	○	○	
35.	Blood transfusion?	○	○		62.	A history of drug abuse?	○	○	
36.	Blood disorder / anemia?	○	○		63.	A history of alcohol abuse?	○	○	
37.	Bruise easily?	○	○		64.	Contact lenses?	○	○	
38.	Abnormal bleeding?	○	○		65.	Eye disease / glaucoma?	○	○	
39.	Jaundice, hepatitis?	○	○		66.	Mental health problems?	○	○	
40.	Other liver disease?	○	○		67.	A removable dental appliance?	○	○	
41.	Infectious mononucleosis?	○	○		68.	Pain / clicking of jaws?	○	○	

 Name: _____

Medications:

70. **Are you now taking any kind of medicine, drug or pills for any purpose?**---------- Yes ○ No ○
71. Anticoagulants?---------- Yes ○ No ○
72. Tranquilizers?---------- Yes ○ No ○
73. Cortisone?---------- Yes ○ No ○
74. Other medications? (Please list) _____

Allergies:

75. **Are you allergic to or had a reaction to local anesthetics?**---------- Yes ○ No ○
76. Penicillin?---------- Yes ○ No ○
77. Other antibiotics? Please List:_____ Yes ○ No ○
78. Latex, nickel?---------- Yes ○ No ○
79. Aspirin?---------- Yes ○ No ○
80. Codeine or other narcotics?---------- Yes ○ No ○
81. Other medications?---------- Yes ○ No ○
82. Allergies other than drug allergies?---------- Yes ○ No ○
    Please List_____

Women:

83. Is there a possibility that you may be pregnant?---------- Yes ○ No ○
84. Estimated delivery date?_____
85. Are you nursing?---------- Yes ○ No ○
86. Are you taking birth control pills?---------- Yes ○ No ○

WOMEN NOTE: Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your Physician / gynecologist for assistance regarding additional methods of birth control.

IS THERE ANY CONDITION CONCERNING YOUR HEALTH THAT THE DOCTOR SHOULD BE TOLD?------ Yes ○ No ○

Is there a family history of--------87. Cancer---------- Yes ○ No ○ 89. Diabetes---------- Yes ○ No ○
88. Heart disease------- Yes ○ No ○ 90. Anesthetic Problems-------- --- Yes ○ No ○

91. Do you have a history of Biphosphonate therapy (i.e. Zometa, Aredia, Fosamax) therapy? ---------- Yes ○ No ○
92. Do you object to the use of your photographs for educational, research or promotional purposes? ----- Yes ○ No ○

I certify that I have read the questions above. I acknowledge that my questions, if any, about the inquires set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his / her staff, responsible for any errors or omissions that I have made in the completion of this form.

-CONSENT FOR TREATMENT AND ANESTHESIA-

The consent and the nature of the dental and / or surgical treatment have been fully explained to me. I have been fully informed of, and understand all the risks to me in the performance of the treatment to be rendered. I understand that there is a possibility of complications developing during or after treatment and these have been explained to me. I have been informed that some possible complications are pain, infection, swelling, bleeding, bruising, temporary or permanent numbness and tingling of the lip, chin, tongue, gums, cheek or teeth, fractured root tips, separated endodontic instruments, trismus (difficulty with opening of the mouth), and unfavorable reactions to drugs and anesthetics. I understand that alternate methods to the proposed procedure(s) as they are available to treat my dental disorder were fully described to me prior to the performance of treatment.

I am now giving my free and voluntary informed consent for the treatment to be rendered. I have not been given or received any guarantee as to the results to be obtained from the treatment I am to receive. I have been told that there will be anesthesia administered (when necessary), as well as the type and nature of such anesthesia, as well as any risks involved in the administration of the anesthesia as well as the anesthesia itself. The above has been fully explained to me, and I do give my free and voluntary informed consent to the same.

I will not use alcohol or take any medications or drugs (other than those prescribed) without first consulting with the doctor.

_____ _____

Date Signature of Patient (Parent or Guardian if Minor)

_____

Witness

Dedicated
Dental
Services, P.C.

Thomas Williams D.M.D.
609 Main Street, P.O. Box 327
Sparkill, New York 10976

Phone: 845 359-0288 Fax: 845 359-6022

PATIENT CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);

Obtaining payment from third party payers (e.g. my insurance company);

The day-to-day healthcare operations of your practice (e.g. Confirming appointments).

I have also been informed of, and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and healthcare operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this _____day of _____, 20_____.

Patient Name (PLEASE PRINT):

_____

Relationship to Patient: _____

Signature: _____