Chart #: _____
FOR OFFICE USE ONLY

## Patient Information

Patient Name: _____ Date: _____
Last, First MI (Preferred Name).
Gender: _____ Family Status: □ Single □ Married □ Child □ Email: _____
Social Security #: _____ Birth Date: ___Driver's License: _____
Phone (Home): _____ (Work): _____ Ext: _____ Cell Phone: _____
Address: _____

## Referral Information

Whom may we thank for referring you to our practice? ☐Another patient, friend ☐ Another patient, relative

☐ Dental Office ☐ Yellow Pages ☐ Online ☐ School ☐ Work ☐ Other _____

Name of person or office referring you to our practice: _____

## Insurance Information

**Primary**
Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI
Insured's Birth Date: _____ ID #: _____ Group #: _____
Insured's Address: _____
Street City State Zip Code
Insured's Employer Name: _____
Address: _____
Street City State Zip Code
Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____
Insurance Plan Name and Address: _____

**Secondary**
Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI
Insured's Birth Date: _____ ID #: _____ Group #: _____
Insured's Address: _____
Street City State Zip Code
Insured's Employer Name: _____
Address: _____
Street City State Zip Code
Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____
Insurance Plan Name and Address: _____

## Responsible Party Information

Person Responsible for Account: ☐ Patient ☐ Father ☐ Mother ☐ Guardian

Name: _____
Method of Payment: ( ) Check ( ) Visa/Mastercard ( ) Discover ( ) Care Credit ( ) Cash
Where appropriate and necessary, credit bureau reports will be obtained.

Authorization: I hereby authorize payment directly to Dr. Robert L. Williamson, III, D. D.S., P.A., of the group insurance benefits otherwise payable to me. I understand that Dr. Robert L. Williamson, III, D.D.S., P.A., is not in network with any insurance company. I understand that I am responsible for all cost of dental treatment. I hereby authorize the Dental office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the medical history are correct to the best of my knowledge.

● Signature of Responsible Party: _____ Date: _____

## Health Information

Date of Last Dental Visit: _____ Reason for this visit: _____

**Dental History:** Would you describe your present dental health as good? ☐ Yes ☐ No

If no, please explain: _____

- Do you think you have active decay or gum disease? ☐ Yes ☐ No
  Please explain: _____
- Do your gums ever bleed? ☐ Yes ☐ No
  If yes, when? _____
- How often do you brush? _____ Floss? _____
- Do you feel nervous about dental treatment? ☐ Yes ☐ No
- Have you ever had a bad experience in a dental office? ☐ Yes ☐ No
  Describe: _____
- Have you ever had braces? ☐ Yes ☐ No
- Is your water fluoridated? ☐ Yes ☐ No
- Have you had any prior dental trauma? ☐ Yes ☐ No
  If yes, please explain: _____
- Do you like your smile? ☐ Yes ☐ No
  If no, please explain: _____
- Name of your previous dentist: _____

**Medical History:** Medical Doctor's Name and Phone #: _____

- Are you under a physician's care now? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you been hospitalized in the past two years? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you taking any medications, pills, drugs, or herbal supplements? ☐ Yes ☐ No
  If yes, please describe what, why, and dosage: _____

_____

_____

- Are you allergic to **PENICILLIN, CODEINE,** or any other medication? ☐ Yes ☐ No
  If yes, list medication and describe reaction: _____
- Pregnant or nursing? ☐ Yes ☐ No
- Do you take premedication for dental treatment? ☐ Yes ☐ No
- Do you smoke? ☐ Yes ☐ No
- Do you use alcohol? ☐ Yes ☐ No
- Are your immunizations up to date? ☐ Yes ☐ No
- **ARE YOU ALLERGIC TO LATEX?** ☐ Yes ☐ No

**Have you ever had any of the following? Please check those that apply:**

| | | | |
|---|---|---|---|
| ☐ Heart Trouble | ☐ Glaucoma | ☐ Artificial Heart Valve | ☐ Ulcers |
| ☐ High Blood Pressure | ☐ Congenital Heart | ☐ Pregnancy | ☐ Chemotherapy |
| ☐ Heart Murmur | Lesion | Due date: _____ | ☐ Pain in Jaw Joint |
| ☐ Mitral Valve Prolapse | ☐ Allergies | ☐ Radiation Treatment | ☐ Hypoglycemia |
| ☐ Arthritis/Gout | ☐ Heart Pacemaker | ☐ Respiratory Problems | ☐ Epilepsy/Seizures |
| ☐ Artificial Joints/Hip | ☐ Heart Surgery | ☐ Rheumatic Fever | ☐ Venereal Disease |
| ☐ Asthma | ☐ Anemia | ☐ Rheumatism | ☐ HIV Positive |
| ☐ Blood Disease | ☐ Hepatitis A (Infect) | ☐ Sinus Problems | ☐ Aids |
| ☐ Cancer | ☐ Hepatitis B (Serum) | ☐ Thyroid Problems | ☐ Cold sores/fever |
| ☐ Diabetes | ☐ Hepatitis C (Serum) | ☐ Stroke | blisters |
| ☐ Dizziness | ☐ Kidney Disease | ☐ ADD/ADHD | ☐ Herpes |
| ☐ Epilepsy | ☐ Liver Disease | ☐ Drug Addiction | ☐ Eating Disorder |
| ☐ Excessive Thirst | ☐ Lung Disease | ☐ Tuberculosis | ☐ Psychiatric Problems |
| ☐ Fainting/Dizziness | ☐ Nervous Disorders | ☐ Jaundice | ☐ Frequent headache |

Please list any other serious illness if not indicated above: _____

- I understand that if any change occurs in my health, I am to report it to the dental office as soon as possible. I have read and understand each question and have answered all of them truthfully and to the best of my ability. I have discussed my health history with the doctor.

_____

Signature of patient, parent or guardian Date

_____

Signature of Doctor Date

## Raleigh Comprehensive & Cosmetic Dentistry
## Robert L. Williamson, III, DDS, PA & Associates

# Financial Policy

Thank you for choosing our office for your dental treatment needs. We are committed to your dental health. Please understand that *payment of your bill is considered a part of your dental treatment.* The following is a supplement to our **Payment Policy**.

- ✓ Please be aware that you are responsible for all payments for treatment. If you are insured, you are responsible for any and all amounts that your insurance does not cover. All children under the age of 18 years old are the responsibility, financially, of the parent or guardian.

- ✓ ***Payment is expected in full for each appointment as services are rendered.*** For the convenience of our patients, we accept cash, personal checks (we do not accept post dated checks), MasterCard, Visa, and Discover. Additionally, we offer CareCredit for financing options.

- ✓ ***Dental Insurance Payments –*** There is **NO** direct relationship between our office and your dental insurance company. The type of plan chosen by you, and/or your employer determines your insurance benefits/coverage. As such, we have no say in the selection of your coverage, no control over the terms of your contract, the methods of reimbursement/payments for treatment, or the determination of your insurance benefits payments. Please note, any balances remaining after your insurance payments is your responsibility

We recognize that under unusual circumstances an account balance may be incurred. *Raleigh Comprehensive & Cosmetic Dentistry* requires that all outstanding balances be ***paid in full within thirty (30) days*** unless other arrangements have been made. If we have not received payment or you have not contacted us within thirty (30) days, further action may be taken with a collection agency or with Small Claims Court. We reserve the right to apply an interest rate of fifteen percent (15%) from the date of service. A $35 fee will be assessed to all returned checks. Thank you in advance for your understanding of our financial policy!

Signature _____ Date _____

**Raleigh Comprehensive & Cosmetic Dentistry**
**Robert L. Williamson, III, DDS, PA & Associates**

# Insurance Submission, Estimates, and Payments

Patient Name & Address: _____
_____
_____

I understand that my insurance is filed as a courtesy. Raleigh Comprehensive & Cosmetic Dentistry will file insurance and accept assignment of benefits (the amount of insurance coverage is paid directly to our office). All costs, "patient portions" are an estimate of the amount my insurance company states it will cover based on percentages. However, deductibles, denial of benefits, waiting periods, fixed fee schedules, non-duplicating clauses, and changes in the policy of the insurance company may impact coverage amounts. Remainders may be left after insurance has paid our office which you will be billed for and be responsible for at that time.

I also understand that if my insurance company does not allow assignment of benefits the insurance payment is mailed directly to me, the subscriber, it is my responsibility to submit the payment to Raleigh Comprehensive & Cosmetic Dentistry for services rendered. I understand cashing this payment and keeping this payment is fraud and punishable by law.

***DENTAL INSURANCE:***
There is **NO** direct relationship between our office and your dental insurance company. The type of plan chosen by you, and/or your employer determines your insurance benefits. As such, we have no say in the selection of your coverage, no control over the terms of your contract, the methods of reimbursement or the determination of your insurance benefits payments.

_____ _____
Signature Date