GREGORY A. WILLIAMS
DMD, PC

Patient Information

Patient Name:_____Date:_____
Last First MI

Social Security# _____ Birth Date: _____Age: _____ Gender: _____Marital Status: _____

Phone (Home): _____ (work): _____ (Cell): _____ Email: _____

Would you like confirmations via (please circle one): phone call email text

Address: _____
Street Apartment# City State Zip code

Employer: _____ Occupation: _____ Years at Job: _____

In case of Emergency Contact:_____
Name Relationship Home Phone Cell Phone

Whom may we thank for referring you to our practice?:_____

Spouse or Responsible Party Information

The following is for (please circle one): patient's spouse patient's guardian

Name: _____Gender: _____ Marital Status:_____

Social Security #: _____Birth Date: _____ Employer: _____

Phone (Home): _____(work): _____ Ext: _____(Cell): _____

Address:_____
Street Apartment# City State Zip code

Insurance Information

Primary Dental Insurance:

Insured/Policy Holder: _____ Birth Date: _____ SS#/ ID#_____

Insured Employer: _____Relationship to Insured: _____

Ins. Company: _____ Ins. Address: _____

City: _____ State: _____ Zip: _____ Ins. Phone _____

Group #: _____

Secondary Dental Insurance:

Insured/Policy Holder: _____Birth Date: _____ SS# /ID#_____

Insured Employer: _____Relationship to Insured: _____

Ins. Company: _____Ins. Address: _____

City: _____ State: _____ Zip: _____Ins. Phone _____

Group #: _____

Consent

I, the undersigned, hereby authorize the Doctor to take radiographs, study models, photographs, or any other diagnostic aids he/she deems appropriate to make a thorough diagnosis of my dental needs. I also authorize the Doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I authorize and consent that the Doctor employ any such assistance as he/she deems appropriate.

I further authorize the release of any information, including the diagnosis, radiographs and records of any treatments or examinations rendered to my insurance company, consulting professionals or others that may request my records.
I certify that the above insurance information, if applicable, is correct and in force. I am aware that it is my responsibility to read and understand my own dental insurance policy, including benefits, limitations and exclusions. I understand that filing of insurance claims is my responsibility and may be provided as a service to me by Dr Greg Williams DMD, PC, and that any agreement for dental coverage is between my insurance company and myself. I understand that an estimated portion is due at the time of service and is estimated according to expected coverage, which may not be disclosed nor guaranteed by my insurance company. I understand my portion may be more if my insurance company does not pay the anticipated amount. I also understand that services are rendered independent of insurance reimbursement.

I understand that I am personally responsible for payment of all fees for dental services provided in this office for me or my dependents, regardless of insurance coverage. Breach of this responsibility carries the penalty of compensating the practice for any related attorney's and collection fees. I understand that payment is due when services are rendered. Any other arrangements for payment must be made before treatment begins. I agree that credit bureau reports may be obtained, where appropriate. I will notify Dr Greg Williams DMD, PC if there is a change in the family relationship on the account (divorce, separation, adoption).

_____

Signature Date Relationship to Patient