Patient Information
Dr. Wade Williams D.D.S., M.S.

Nickname: _____

Last: _____ First: _____ M.I.: _____

Sex M / F Age: _____ Birthdate: _____ Hobby/Interests: _____

School: _____ Grade: _____ Cell Phone: (____) _____

Father's Name: _____ Employed By: _____

Address: _____ Work Phone: (____) _____

City, State & Zip: _____ Home Phone: (____) _____

SS#: _____ Cell Phone: (____) _____

Birthdate _____ Email: _____

Mother's Name: _____ Employed By: _____

Address: _____ Work Phone: (____) _____

City, State & Zip: _____ Home Phone: (____) _____

SS#: _____ Cell Phone: (____) _____

Birthdate _____ Email: _____

Patient's Dentist: _____ City: _____

Whom may we thank for referring you to this office: _____

Relatives treated by Dr. Williams: _____

Please Complete Medical History

Unfavorable reaction to any medication: (list) _____

Asthma, allergies	Yes/No	AIDS	Yes/No
Hepatitis	Yes/No	Herpes	Yes/No
Jaundice	Yes/No	VD: Syphilis, Gonorrhea	Yes/No
Rheumatic Fever	Yes/No	Discomfort or injury in face, head, neck	Yes/No
Hemophilia (bleeding)	Yes/No	Swelling or lumps in mouth	Yes/No
Sinus Problems	Yes/No	Recurring Sore in or around mouth	Yes/No
Headaches, Migraines	Yes/No	Diabetes	Yes/No
Jaw Clicking / Popping	Yes/No	Epilepsy	Yes/No
Heart Murmur	Yes/No	Cancer/Tumors	Yes/No
Heart Trouble	Yes/No	Anemia	Yes/No
Glaucoma	Yes/No	Other: _____	
Bone Disorders	Yes/No		
Thyroid / Endocrine Disorder	Yes/No		

Patient's Habits: Thumbsucker ____ Mouth Breather ____ Lisper ____ Tonsils / Adenoids present ____ Removed (date) _____

The information above is correct to the best of my knowledge. I give my consent to have the recommended treatment for my child only after it has been mutually approved.

Signature: _____ ***Date:*** _____

ORTHODONTICS
WADE WILLIAMS, D.D.S., M.S.

Wade Williams Orthodontics Financial Policy

Welcome, and thank you for choosing *Wade Williams Orthodontics* for your orthodontic care. We are dedicated to creating beautiful smiles by providing personalized quality orthodontic care in a fun and comfortable environment. So that we may help you avoid any frustration or confusion regarding our office policies, we have prepared the following summary for you. We are confident that you will experience orthodontic excellence in our office. After reading this policy and your questions have been answered, please initial the following.

_____ **Broken Appointments and Late Cancellations:** Because you are important to us, your appointment time is reserved especially for you and we strive to be on time so we minimize your wait time. Broken appointments result in the loss of valuable time where we could have served another patient. There will be a fee of $70.00 for any missed or cancelled appointment without 24 hours notice. We will allow one broken appointment at no charge and all subsequent broken appointments will be charged per patient. Please help us to avoid this fee by keeping your scheduled appointments. Additionally, if you arrive late for your appointment we will do everything we can to help keep your appointment. If you are too late to allow us to see you, we will have to reschedule your appointment and you will be responsible for the broken appointment fee.

_____ **Insurance:** We will file a claim to your insurance as a courtesy to you, however, we must emphasize that our relationship is with you, not your insurance. We make every effort to accurately quote what we anticipate your insurance will cover. This is *only an estimate* and we cannot be responsible for what your insurance finally covers. If for any reason your insurance does not cover the estimated amount or if your insurance terminates at any point during treatment you will be responsible to pay your insurance portion. Furthermore, it is your responsibility to know your insurance policy and to notify us if there are any changes.

_____ **Monthly Payments:** All payments are due on the first of each month. We require monthly automatic payments to be set up on the credit or debit card of your choice on the first of each month. If there are extenuating circumstances that prevent you from setting up automatic payments we require post-dated checks on file paid one month in advance.

_____ **Returned Checks:** There is a $35.00 fee for returned checks. If we receive a returned check we will attempt to notify you by phone and we will attempt to run the check again or set up alternate payment arrangements if need be. If we run the check again and it is returned a second time, by law, we are obligated to turn the check in to the Montgomery County Sheriff's Department. If this happens we will have to have payment by cash, credit card or money order for all future payments.

Your attention to these policies will go far in providing you with the very best orthodontic care we can provide.

I HAVE READ AND AGREE TO THE ABOVE POLICIES AND I RECEIVED A COPY OF THEM.

_____ _____

Signature Date

_____

Witness

Wade Williams D.D.S.,M.S.
1001 Medical Plaza Dr. Ste #350
The Woodlands, TX. 77380

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, _____, (parent of, if a minor) have received a copy of this office's Notice of Privacy Practices.

_____
Please Print Name Of Patient

_____
Signature

_____
Date

I, _____, will allow the above named entity to disclose my health information to: (List Names and relationship below)

Name	relationship to patient
_____	_____
_____	_____
_____	_____
_____	_____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

_____ Individual refused to sign

_____ Communications barriers prohibited obtaining the acknowledgement

_____ An emergency situation prevented us from obtaining acknowledgement

_____ Other (Please specify)

_____

_____

_____