William Lee Willis, DDS, PC
2510 N.W. Kline St. - Roseburg, OR 97471
541-672-4899

All About You

Today's Date:_____
Name:_____
Birth Date: _____
Social Security #:_____
Mailing Address:_____
_____
Home Phone: _____
Cell Phone:_____
Email: _____
Work Phone:_____
Employer: _____
May we contact you at work regarding your appointments? No Yes
Are you a student: No Yes
School attending: _____
Male / Female Single / Married
Last dental visit: _____

Guarantor on Account

(Statements will be sent to this person/address)

Name:_____
Address: _____
_____
Birth Date:_____
Relationship: _____

Spouse or Parent Information

Name:_____
Mailing Address:_____
_____
Birth Date: _____

Emergency Contact

(A friend/relative not living with you)

Name: _____
Relationship: _____
Primary Contact Phone: _____
Alternate Phone: _____

Primary Dental Insurance

Insurance Company: _____
Ins. Co. Address: _____
_____
Insured's Name: _____
Insured's Birth Date: _____
Subscriber ID#:_____
Group #: _____
Insured's Employer: _____
Relationship to Insured: _____
Ins. Co. Telephone: _____

Secondary Dental Insurance

Insurance Company: _____
Ins. Co. Address: _____
_____
Insured's Name: _____
Insured's Birth Date: _____
Subscriber ID#: _____
Group #: _____
Insured's Employer: _____
Relationship to Insured: _____
Ins. Co. Telephone: _____

Who can we thank for referring you?

_____

Certificate of Consent

A parent or legal guardian of any/all patients under the age of 18 *MUST* sign below. I authorize Dr. William Lee Willis to provide dental services for this child/minor.

_____
Parent/Legal Guardian Signature Date

A Note For Our Patients

The cost of your dental care is ultimately your responsibility. We bill your insurance company/companies as a courtesy to you. Your insurance policy is a contract between you, your employer and your insurance company. Payment at the time of service is required.
Thank you.

Patient name:_____ DOB:_____

Your Current Physical Health

Good Fair Poor

Have you had any of the following conditions?

Anemia	Yes	No
Anorexia/Bulimia	Yes	No
Asthma	Yes	No
Back/Neck Pain	Yes	No
Cancer	Yes	No
Chemo/Radiation Therapy	Yes	No
Drug/Alcohol Abuse	Yes	No
Epilepsy	Yes	No
Glaucoma	Yes	No
Heart Murmur	Yes	No
Heart Surgery	Yes	No
Hemophilia	Yes	No
High Blood Pressure	Yes	No
HIV/AIDS	Yes	No
Kidney Disease	Yes	No
Mitral Valve prolapse	Yes	No
Pacemaker	Yes	No
Periodontal Disease	Yes	No
Rheumatic Fever	Yes	No
Seasonal Allergies	Yes	No
Severe/Frequent Headaches	Yes	No
Sinus Problems	Yes	No
Stroke	Yes	No
TMD/TMJ Problems	Yes	No
Tuberculosis	Yes	No
Ulcers	Yes	No
Venereal Disease	Yes	No
Artificial Joints/Valves	Yes	No

If "yes" What?_____

When?_____

Diabetes Yes ____ No

If 'yes' what type? Type I Type II

Hepatitis Yes __ No

If 'yes' what type? A B C D

Have you ever received a blood transfusion? _____

If 'yes' what was the approximate date?

_____

Osteoporosis Yes No

If 'yes' what medication do you take for it?_____

For Women

Do you take birth control?	Yes	No
Are you currently pregnant?	Yes	No

If 'yes',how many weeks? _____

Are you nursing?	Yes	No

Antibiotic Disclaimer

If given any antibiotics while on birth control, I understand that the birth control may become ineffective through the duration of use and seven days after, I understand to take further precautions

Allergies

Are you allergic to any of the following?

Aspirin	Yes	No
Penicillin	Yes	No
Tetracycline	Yes	No
Erythromycin	Yes	No
Codeine	Yes	No
Latex	Yes	No

Do you have any other allergies? Please list below:

_____

_____

Medication List

Name Dose Reason

_____

_____

_____

_____

_____

Do you smoke? YES ___NO ___Packs per day? _____

Primary Care Physician: _____

Primary Care Phys. Phone: _____

The answers given to these questions are for my dental records only and are to be considered confidential. The information is complete, to date, and you have my permission to discuss any portion of it with my physician. I understand that it is my responsibility to inform this office of any and all changes in my medical and/or personal information, including changes to contact information, insurance carriers or coverage status. I acknowledge that I am ultimately responsible for any/all claims that remain unpaid by my insurance company/companies after 90 days, and that this office *may* charge additional fees for re-submissions of claims with narratives and or duplicate diagnostic materials.

_____

Patient/Parent or Guardian Signature Date

One Year Update below:

_____

Patient/Parent or Guardian Signature Date

Dr. William Lee Willis, DDS, PC
2510 NW Kline St.
Roseburg, OR 97471

GENERAL CONSENT TO DENTAL TREATMENT

I hereby consent to the performance of dental treatment by Dr. William Lee Willis.

I further consent to such other additional treatment, whether described above, as may be indicated by sound and prudent dental practices if during the treatment described above, unforeseen conditions are discovered or unusual conditions develop.

Should the use of anesthesia and sedative agents be indicated, I consent to the administration of such anesthetics and sedative agents as the doctor may deem advisable and proper.

I further consent to the taking of photographs and radiographs (x-rays) for the treatment to be performed, including appropriate portions of the head, neck and oral cavity for dental educational and scientific purposes, and the demonstration or publication of such photographs and radiographs so long as my identity is not revealed during said demonstration or in descriptive material accompanying the publication.

The nature and purpose of the treatment to be rendered, the possible hazards and the alternative methods of treatment have been fully discussed and explained to me and no guarantee or warranty has been made to me that the results will be to my complete satisfaction.

Additionally, I understand that inappropriate behavior is not tolerated at this office and continued such behavior may lead to dismissal from our office. We have the right to refuse service to anyone.

Scheduling / Cancellation Policy

We will make every effort to accommodate your scheduling needs. In return, we ask that you help us by keeping your scheduled appointments and/or by notifying us in advance if you are unable to do so. With advance notice, we are often able to accommodate other patients that are waiting to get an appointment. Please read and sign our policy statement below: All appointments that are canceled with less than 24 business hours' advance notice are subject to a missed appointment fee. Please note that this is NOT covered by insurance companies. It is the patient's responsibility.

- If you need to cancel an appointment, please do so at least 24 hours in advance on business days.
- If you fail to arrive for your appointment, and you have not notified our office, you will be charged $59.00 for a missed appointment. Additionally, any patients over 10 minutes late to their appointment may be charged the fee and rescheduled, to keep a timely schedule and avoid running late into other patient's appointments.
- If you fail to arrive for two consecutive appointments, we will cancel all the remaining appointments, and you must prepay for any future appointments to get back on our schedule. Additionally, you will be charged the full amount of the visit fee. If missed appointments continue you may be dismissed from the office.

We enforce this policy out of a desire to provide each of our patients with continuity of care and effective treatment. We thank you for your assistance in complying with this and we appreciate your cooperation. We hope your experience here is positive and healthy.

My signature below represents that I have read, understand and consent to dental treatment.

Patient or Patient's Parent or Legal Guardian's Signature **Date**

Dr. William Lee Willis
2510 N.W. Kline St.
Roseburg, OR 97471

HIPAA NOTICE: PATIENT PRIVACY NOTICE

We are committed to preserving the privacy of your protected health information (P.H.I.). We are also required by law to protect the privacy of your medical information and to provide you with a notice describing:

** How medical information about you may be used and disclosed, and how you can access this information.**

We are required by law to have your written consent before we use or disclose to others your medical information for the purposes of providing or arranging for your health care, the payment for or the reimbursement of the care that we provide to you, and the related administrative activities supporting your treatment.

We have available a detailed NOTICE OF PRIVACY PRACTICES which fully explains your rights and our obligations under the law. We may revise our NOTICE from time to time. You have the right to receive a copy of our most current NOTICE in effect. If you desire, we will provide you with a copy.

I hereby grant permission to Dr. Willis and his staff to:

_____ Yes _____ No **Use and disclose health information about me to provide myself with medical treatment or services. Dr. Willis may disclose health information about me to doctors, nurses, technicians, office staff or other personnel who are involved in taking care of me and/or my health.

_____ Yes _____ No **Use and disclose health information about me so that treatment and services I receive at this office may be billed, and any payment will be collected from me, an insurance company, or a third party. Dr. Willis may also tell my dental plan about the treatment I am going to receive to obtain prior approval, or to determine whether my plan will cover the treatment.

The following are people who may be contacted, other than health-care personnel, and receive information about my account information and/or my treatment plan information:

Name	Relationship	Number
Name	Relationship	Number

I understand that I have the right and access to this privacy notice if I request it. I understand that my personal information will only be used when my health care or health related issues are a concern.

_____

Patient's, Parent's, or Legal Guardian's Signature Date

Dr. Lee Willis DDS, IBO
Cosmetic & General Dentistry
TMJ & Orthodontics

Dental Records Release Form

TO: _____ Fax: _____

PATIENT NAME:_____ DOB:_____

I request and authorize the above-named doctor or health care provider to release the information specified below to the organization, agency or individual named on this request.

RELEASE TO:

Name of Dental Practice: Dr. Lee Willis DDS, IBO

Address: 2510 NW Kline Street, Roseburg OR 97471

Telephone Number: 541-672-4899 Fax Number: 541-957-9907 Email: drleewillisddspc@hotmail.com

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INFORMATION REQUESTED:

____Copy of treatment records/recommendations

____Copy of dental x-rays

Date of last FMX OR PANO: _____

_____ _____

Patient Signature Date