DECATUR COMPREHENSIVE DENTISTRY, L.L.C.

Thomas T. Willis D.M.D., M.A.G.D.
Kimberly J. Welden D.M.D.
Brian G. Ondocsin D.M.D.

Welcome to our office!

Thank you for choosing Decatur Comprehensive Dentistry. We welcome the opportunity to serve you. Our well trained and highly experienced dentists and staff are prepared to treat all aspects of your dental needs. Our primary goal is to provide you with safe, sound dental care that is sensitive to your individual needs.

Office Hours and Location

Our office is open Monday through Thursday from 8AM until 5PM and select Fridays from 8am until 12PM. We close between 1PM and 2PM for lunch. Our office is located at 2691-C Sandlin Road, Decatur, Alabama. We value your time, and make every effort to reduce your wait. We ask that you be on time or a few minutes early for your appointment. If you are more than 15 minutes late you may be asked to reschedule. If you find the need to cancel an appointment, please call the office as soon as possible. This small courtesy is greatly appreciated, as it may help other patients get in to see their dentist sooner. If you miss an appointment without a 24 hour prior notice you may be charged a $25.00 fee.

Financial and Insurance Policy

We will file insurance claims with your insurance provider as a courtesy to you. However, all charges to your account are your responsibility. Any deductibles or co-pays are due in full at the time of service. There will be a service charge of $25.00 on all returned checks. We accept cash, check, Visa, Mastercard, Discover, American Express, Debit Card and CareCredit.

Concerns and Complaints

We want you to be satisfied with the service, care and treatment that we provide. If you have any concerns or complaints, please let us know as soon as possible. We will strive to immediately address your concerns or resolve your complaints. Please know that your future care and treatment will not be compromised under any circumstance.

More Information

For more detailed information on our dentist, staff and services, please visit our website at: www.decaturcomprehensivedentistry.com

PATIENT INFORMATION

Date_____

Patient's name _____
Last First Middle Nickname

Address_____
Street City State Zip Code

Home Phone (___) _____-_____Cell Phone (___) _____-_____Work number_(____)_____-_____

Birth Date_____ **Social Security Number**_____ ___ __ _____

Email address_____

If patient is a minor, give parent's or guardian's name _____

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

RESPONSIBLE PARTY INFORMATION

Name_____ _____
Last First Middle Marital Status

Residence_____
Street City State Zip

Mailing Address_____
Street City State Zip

How long at this address _____ ____ **Home Phone (___) _____-_____ Work Phone (___) _____-_____**

Previous Address (if less than 3 years) _____
Street City State Zip

Social Security # _____Birth Date _____Relationship to Patient_____

Employer _____ **Occupation** __ _____ **No. Years Employed**_____

Spouse's Name_____ ____ **Relationship to Patient**_____
Last First Middle

Employer _____ **No. Years Employed**_____

Social Security # _____ ____ _____ **Birth Date** _____ **Work Phone (___) _____-_____**

INSURANCE INFORMATION

Insured's Name _____ **Contract #**_____ _____
Group #_____ **Insurance Company**_____

Insurance Company Address_____

Do you have dual coverage? YES __ NO__ **If yes:**
Insured's Name_____ **Insured's Social Security #**_____

Contract#_____ **Group #**_____

Insurance Company_____ **Insured's Employer**_____

Insurance Company Address_____

Emergency Information

Name of nearest relative not living with you_____

Complete Address_____

Home Phone (___) _____-_____ Cell Phone (___) _____-_____

I understand that where appropriate, credit bureau reports may be obtained. Initial_____

Signature (Parent's signature if minor)_____

Updates (date & Initial) _____

Patient Name	
Patient Account No.	Medical Alert

DENTAL HISTORY

Welcome! So that we may provide you with the best possible care please complete both sides of this medical/dental history form. All information is completely confidential.

What is the reason for your visit today? _____

_____

Date of Last Dental Visit_____ **Last Dental Cleaning** _____ **Last Full Mouth X-rays**_____

What was done at your last dental visit? _____

_____

Previous Dentist's Name _____

Address _____ State _____ Zip _____

Telephone_____

How often do you have dental examinations?_____

How often do you brush your teeth? _____ How often do you floss? _____

What other dental aids do you use? (Interplak, toothpick, etc.) _____

Do you have any dental problems now? Yes No

If yes, please describe: _____

Are any of your teeth sensitive to:

Hot or cold?	Yes	No
Sweets?	Yes	No
Biting or Chewing?	Yes	No
Have you noticed any mouth odors or bad tastes?	Yes	No
Do you frequently get cold sores, blisters or any other oral lesions?	Yes	No

Do your gums bleed or hurt? Yes No

Have your parents experienced gum disease or tooth loss?	Yes	No
Have you noticed any loose teeth or change in your bite?	Yes	No
Does food tend to become caught in between your teeth?	Yes	No

If yes, where? _____

Do you:

Clench or grind your teeth while awake or asleep?	Yes	No
Bite your lips or cheeks regularly?	Yes	No
Hold foreign objects with your teeth? (pencils, pipe, pins, nails, fingernails)	Yes	No
Mouth breathe while awake or asleep?	Yes	No
Have tired jaws, especially in the morning?	Yes	No
Smoke/chew tobacco?	Yes	No

Have you ever had:

Orthodontic treatment?	Yes	No
Oral surgery?	Yes	No
Periodontal treatment?	Yes	No
Your teeth ground or the bite adjusted?	Yes	No
A bite plate or mouth guard?	Yes	No
A serious injury to the mouth or head?	Yes	No

If so, please describe, including cause _____

_____

Have you experienced:

Clicking or popping of the jaw?	Yes	No
Pain? (joint, ear, side of face)	Yes	No
Difficulty in opening or closing the mouth?	Yes	No
Difficulty in chewing on either side of the mouth?	Yes	No
Headaches, neckaches or shoulder aches?	Yes	No
Sore muscles (neck, shoulders)?	Yes	No

Are you satisfied with your teeth's appearance?	Yes	No
Would you like to keep all of your teeth all of your life?	Yes	No
Do you feel nervous about having dental treatment?	Yes	No

If so, what is your biggest concern?

_____

Have you ever had an upsetting dental experience? Yes No

If yes, please describe_____

_____

Is there anything else about having dental treatment that you would like us to know? Yes No

If yes, please describe _____

_____

_____

(Please complete other side)

Patient Name	
Patient Account No.	Medical Alert

MEDICAL HISTORY

1. Have you been under the care of a medical doctor during the past two years? ..... Yes No
   If yes, for what? _____
   Physician's Name _____ Phone _____
   Address _____ City _____ State _____ Zip _____
2. Have you taken any medication or drugs during the past two years? ..... Yes No
3. Are you taking any medication, drugs or pills now? ..... Yes No
   If yes, please list name and dosage _____
4. Are you aware of having an allergic **(or adverse reaction)** to any medication or substance? ..... Yes No
   If yes, please list: _____
5. Have you been a patient in the hospital during the past five years? ..... Yes No
6. Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each item.

Heart (Surgery, Disease, Attack)	Yes No	Ulcers	Yes No	Hepatitis A (infectious) B (serum)	Yes No
Chest Pain	Yes No	Diabetes	Yes No	Venereal Disease	Yes No
Congenital Heart Disease	Yes No	Thyroid Problems	Yes No	A.I.D.S.	Yes No
Heart Murmur	Yes No	Glaucoma	Yes No	H.I.V. Positive	Yes No
High Blood Pressure	Yes No	Contact lenses	Yes No	Cold Sores/Fever Blisters	Yes No
Mitral Valve Prolapse	Yes No	Emphysema	Yes No	Blood Transfusion	Yes No
Artifical Heart Valve	Yes No	Chronic Cough	Yes No	Hemophilia	Yes No
Heart Pacemaker	Yes No	Tuberculosis	Yes No	Sickle Cell Disease	Yes No
Rheumatic Fever	Yes No	Asthma	Yes No	Bruise Easily	Yes No
Arthritis/Rheumatism	Yes No	Hay Fever	Yes No	Liver Disease	Yes No
Cortisone Medicine	Yes No	Latex Sensitivity	Yes No	Yellow Jaundice	Yes No
Swollen Ankles	Yes No	Allergies or Hives	Yes No	Neurological Disorders	Yes No
Stroke	Yes No	Sinus Trouble	Yes No	Epilepsy or Seizures	Yes No
Diet (Special/ Restricted)	Yes No	Radiation Therapy	Yes No	Fainting or Dizzy Spells	Yes No
Artificial Joints (hip, knee, etc.)	Yes No	Chemotherapy	Yes No	Nervous/Anxious	Yes No
Kidney Trouble	Yes No	Tumors	Yes No	Psychiatric/Psychological Care	Yes No

7. Do you use more than two pillows to sleep? ..... Yes No
8. Have you lost or gained more than 10 pounds in the past year? ..... Yes No
9. Do you have or have you had any disease, condition, or problem not listed? ..... Yes No
   If yes, please list: _____
10. **Women.** Are you: **Pregnant?** Yes, ___ Months No **Nursing?** Yes No **Taking birth control pills?** Yes No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

Patient /Guardian Signature _____ Date _____

History Review

Dentist Signature _____ Date _____

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2691-C Sandlin Road SW
Decatur, AL 35601
256-350-4616

Financial & Insurance Policy

We will file insurance claims with your insurance provider as a courtesy to you. However, all charges to your account are your responsibility. Your insurance contact is an agreement between you, your employer and your insurance company. **Any deductibles or co-pays are due in full at time of treatment.** If your claim is not paid within 45 days of treatment the remaining balance is your responsibility. Returned checks are processed by a third party and fees are added for collection purposes. We accept cash, check, Visa, Mastercard, Discover, American Express, Debit Card & Care Credit.

I read and understand this financial policy.

_____
Patient's Initials

Appointment Policy

Once you reserve time with either Dr. Willis or your hygienist it is considered a confirmed appointment. You can request a courtesy call as a reminder. We reserve appointments specifically for you and do not double book our time. If an appointment is cancelled or rescheduled without 24 hour notice a broken appointment fee is added to your account and is collectible. If two appointments are missed or cancelled without 24 hour notice, you are placed on a call list and will be worked in as the schedule permits.

I read and understand this appointment policy.

_____
Patient's Initials

Notice of Privacy Practices

I understand I have certain rights to privacy as outlined by the Health Insurance Portability and Accountability Act of 1996 (HIPPA). I have been offered a copy of the Notice of Privacy Practices to review. I understand by signing I authorize Dr. Willis and his practice to use and disclose my protected health information to:

Obtain payment information from third party payers such as my insurance company
Obtain treatment information from other healthcare providers regarding my treatment
Obtain information relating to day to day operations in the practice

_____ _____
Print Patient's Name Date

_____ _____
Patient's Signature Relationship to Patient

Decatur Comprehensive Dentistry
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Decatur, AL 35650
256-350-4616
www.decaturcomprehensivedentistry.com

OFFICE FINANCIAL POLICY

We are pleased that you have chosen us for all your dental needs. We want to establish a long and pleasant relationship with you. We understand that the filing of dental insurance can be a very complicated and time consuming task. We want to assist you in any way possible to receive the maximum benefit from your insurance. We need your understanding and cooperation in the following guidelines regarding the filing of your insurance claims and payment.

1. Dr. Welden is contracted as a preferred provider with Southland and Blue Cross/Blue Shield of Alabama
   Dr. Willis is contracted as a preferred provider with Blue Cross/Blue Shield of Alabama only.
   Dr. Ondocsin is contracted as a preferred provider with Blue Cross/Blue Shield of Alabama, MetLife, Delta Dental and Cigna.

All applicable deductibles, co-pays, and co-insurance amounts are due at the time services are rendered. We accept cash, check, Master Card, Visa, Discover, American Express and Care Credit. Some dental services may not be covered by your contract. In the event a given procedure is not covered, payment for these services is your responsibility. We reserve the right to charge and collect a fee for broken appointments-appointments that are cancelled or broken without a 24 hour notice. If you miss two appointments without a 24 hour cancellation notice you well be charged a $50.00 fee, per scheduled hour if you choose to make a third appointment with the practice. **Appointments are reserved exclusively for you.**

IF YOUR INSURANCE IS NOT WITH ONE OF THE ABOVE COMPANIES, PLEASE SEE FOLLOWING PARAGRAPH.

2. <u>If your insurance is through a company with whom we are not contracted:</u>
   *Please check your contract carefully to determine if you are required to see a Preferred provider for that company. Understand that if you choose to see a Non-preferred provider, your insurance may not pay the full amount or pay for all.
   ***Your insurance is a contract between you and your insurance company. Our office Is not a party to that contract.**
   *While the filing of insurance claims is a courtesy that we gladly extend to you,

ALL CHARGES ARE ULTIMATELY YOUR RESPONSIBILITY FROM THE DATE THE SERVICES ARE RENDERED.

Payment plans, financial arrangements and third party financing are available for comprehensive dental treatment. We have a partnership with Care Credit for third party financing. We also offer In Office Savings Plan and Automatic withdrawal's with the use of your bank debit card. In the event the balance is unpaid and turned over for collection, any and all fees to include (attorney's fees, court cost, filing fees or cost of collections) will be charged to all accounts and will be the responsibility of the patient.

In order to facilitate accurate and prompt reimbursement, we request that you give us complete and correct information. If you have any questions regarding your insurance coverage or our financial policy please do not hesitate to ask. We are happy to help you and appreciate your cooperation. Again, we are very thankful you have chosen us to be your dental care provider. By my signature, I acknowledge that the above policy is understood and I agree to comply with said policy.

Signature of Responsible Party_____

Patient's Name_____

Date_____