MARK J. WILLIAMSON, DDS

WELCOME TO OUR OFFICE

Date: _____

>> PATIENT INFORMATION

First Name | Middle Name | Last Name | Birthdate | Age | Sex

Mailing Address | City, State, Zip | Home Phone

Employer Name | Work Address | Work Phone

Occupation | Social Security No. | Drivers License No. | Marital Status

>> PARTY RESPONSIBLE FOR PAYMENT

First Name | Middle Name | Last Name | Birthdate | Age | Sex

Mailing Address | City, State, Zip | Home Phone

Employer Name | Work Address | Work Phone

Social Security No. | Drivers License No.

>> SPOUSE INFORMATION

First Name | Middle Name | Last Name | Birthdate | Age | Sex

Mailing Address | City, State, Zip | Home Phone

Employer Name | Occupation | Work Phone

Work Address | City, State, Zip

>> IN CASE OF AN EMERGENCY

Nearest relative or acquaintance not living with you

Name | Address | Home Phone

>> DENTAL INSURANCE

❍ YES ❍ NO

Name of Group Dental Program | Group Number

Employer (Company) Name | Work Address

Secondary Insurance | Plan Name / Group No. | Name of Carrier

>> Whom may we thank for referring you to our office?

Name | Address

All services are to be paid in full at the time services are rendered unless previous arrangements are made,

>> PLEASE SIGN HERE: _____

Dr. Mark J. Williamson, DDS
3355 Cherry Ridge, Suite 216 | San Antonio, TX 78230
Office 210.341.2569 | Fax 210.308.9613
DrWilliamson@MJWdental.com | FrontDesk@MJWdental.com | www.MJWdental.com

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MEDICAL QUESTIONNAIRE

Patient Name: _____ **Date:** _____

Today's BP: _____ **Email Address:** _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medications you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under the care of a physician? Yes / No
If yes, please explain: _____
Have you been hospitalized or had a major operation in the last 5 years? Yes / No
If yes, please explain: _____

Have you ever taken Fosamax, Boniva, Actonel, Prolia, Forteo, or Reclast? Yes No
Have you ever had any difficulty with dental extractions or prolonged bleeding? Yes No
Have you ever had any adverse reaction to dental anesthesia? Yes No

CHECK if you HAVE or HAD any of the following.

- ☐ High Blood Pressure
- ☐ Heart Attack
- ☐ Chest Pains
- ☐ Artificial Valves
- ☐ Stents/Bypass
- ☐ Stroke
- ☐ Pacemaker
- ☐ Heart Murmurs
- ☐ Atrial fibrillation /Ablation
- ☐ Mitral Valve Prolapse
- ☐ Rheumatic Fever
- ☐ Swollen Feet/Ankles
- ☐ Circulation Problems
- ☐ Lung Disease
- ☐ Asthma
- ☐ Emphysema
- ☐ COPD
- ☐ Bronchitis
- ☐ Pneumonia
- ☐ Tuberculosis
- ☐ Chronic Cough
- ☐ Shortness of breath

- ☐ Cancer
- ☐ Radiation Treatment
- ☐ Chemotherapy
- ☐ Biopsies
- ☐ Thyroid Hypo/Hyper
- ☐ Osteoporosis
- ☐ Fibromyalgia
- ☐ Blood Disease
- ☐ Excessive Bleeding
- ☐ Anemia
- ☐ Autoimmune Disease
- ☐ Polio
- ☐ Lupus
- ☐ Shortness of Breath
- ☐ Seizure Disorder
- ☐ Epilepsy
- ☐ Nervous Disorder
- ☐ Psychiatric Care
- ☐ PTSD
- ☐ Autism
- ☐ Birth Defects
- Leukemia

- ☐ Glaucoma
- ☐ Dementia
- ☐ Diabetes
- ☐ Liver Disease
- ☐ Hepatitis A B C
- ☐ Kidney Disease
- ☐ ALS
- ☐ Multiple sclerosis
- ☐ Cerebral Palsy
- ☐ Parkinson's
- ☐ Joint Replacement

Antibiotics Required?
Yes No

- ☐ Osteoarthritis
- ☐ Rheumatoid arthritis
- ☐ Surgical Implants
- ☐ Shingles
- ☐ Colitis
- ☐ AIDS/HIV Positive
- ☐ Sexually transmitted disease

IN THE PAST 5 YEARS HAVE YOU HAD

- ☐ Cortisone Treatment
- ☐ Back/Neck Problems
- ☐ Pregnancy
  Nursing
- ☐ Take Birth Control
- ☐ Acid Reflux / GERD/Ulcers
- ☐ Fainting
- ☐ Dizziness
- ☐ Vertigo
- ☐ Headaches
  Frequency? _____
- ☐ Tobacco Spit/Smoke
- ☐ Controlled Substances
- ☐ Insomnia
- ☐ Snoring
- ☐ Sleep Apnea
  Do you wear a device? _____

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Please Describe any Other Medical Conditions Not Described Above

_____

_____

Allergies:

☐ Local Anesthetic ☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Sulfa ☐ Iodine ☐ Latex

Pharmacy Name: _____

Pharmacy Phone Number: _____

List of Physicians, Specialty, Phone Number:

_____ _____

_____ _____

_____ _____

_____ _____

List of Medications:

_____ _____

_____ _____

_____ _____

_____ _____

List of Supplements:

_____ _____

_____ _____

_____ _____

_____ _____

Other Information We Should Know:

_____

In Case of Emergency – Name: _____ **Phone Number:** _____

Authorization:

I have reviewed the information and answered all questions to the best of my knowledge. I understand that this information will be used to determine the dental treatment I receive at this office and may be shared with other medical offices only as necessary. I will notify the office should any information change in the future.

Signature of Patient: _____ **Date:** _____

Dentist/Hygienist Signature: _____ **Date:** _____

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CUSTOMIZED PERSONALITY PROFILE

To serve you better and to give you the individual attention you deserve, please check all the appropriate items below.

I have a fear of or concern about:
- ❍ Experiencing pain
- ❍ Not being numb
- ❍ Needles
- ❍ Unnecessary or wrong treatment
- ❍ Gagging
- ❍ Losing control
- ❍ Having something put over my mouth
- ❍ Being scolded or made to feel ashamed
- ❍ Catching a disease
- ❍ Losing my teeth
- ❍ Having to wear a denture or partial
- ❍ Other _____

The following makes me uncomfortable:
- ❍ The sounds of a dental drill
- ❍ Laying down in a dental chair
- ❍ The smells in a dental office
- ❍ Being numb
- ❍ Having to wait in the reception area
- ❍ Other _____

To understand what's going on in my mouth, my preference is:
- ❍ To know all the details
- ❍ To be given the bottom line
- ❍ To be shown pictures and movies
- ❍ To talk with a team member about solutions to my problems

My dental experiences as an adult have been:
- ❍ Completely pain-free and comfortable
- ❍ Somewhat uncomfortable
- ❍ Painful
- ❍ Traumatic
- ❍ I have not seen the dentist as an adult or my visits have been very few

When I think about coming to the dentist, I feel:
- ❍ Comfortable - I have no anxiety about seeing the dentist or dental procedures
- ❍ Anxious - I don't want to come but I make myself, however I am seldom comfortable
- ❍ Fearful - I have stayed away from the dentist because of my fear and avoid coming unless abolutely necessary
- ❍ Extremely Fearful - I cannot cope with dental visits and have avoided the dentist for years to the detriment of my dental health

I have avoided the dentist because of:
- ❍ Anxiety and fear
- ❍ Budget concerns
- ❍ Time concerns
- ❍ No sense of urgency
- ❍ Lack of trust
- ❍ Other _____

My childhood dental experiences were:
- ❍ Completely pain-free and comfortable
- ❍ Somewhat uncomfortable
- ❍ Painful
- ❍ Traumatic
- ❍ I did not go to the dentist as a child

My immediate concern about my teeth and my smile is _____
_____
_____
_____
_____
_____

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CONSENT FOR USE & DISCLOSURE OF HEALTH INFORMATION

You are entitled to a copy of this consent after you sign it.

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Patient #: _____ Social Security #: _____

SECTION B: TO THE PATIENT - PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Office 210.341.2569 | Fax 210.308.9613
FrontDesk@MJWdental.com
3355 Cherry Ridge, Suite 216 | San Antonio, TX 78230

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____, have had a full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following;

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include completed Consent if the patient's chart.

MARK J. WILLIAMSON, DDS

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement.

I, _____ , have received a copy of this office's Notice of Privacy Practices.

_____
Please Print Name

_____
Signature

_____
Date

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

❍ Communicationns barriers prohibited obtaining the acknowledgement

❍ An emergency situation prevented us from obtaining the acknowledgement

❍ Other (please specify)

_____

_____

_____

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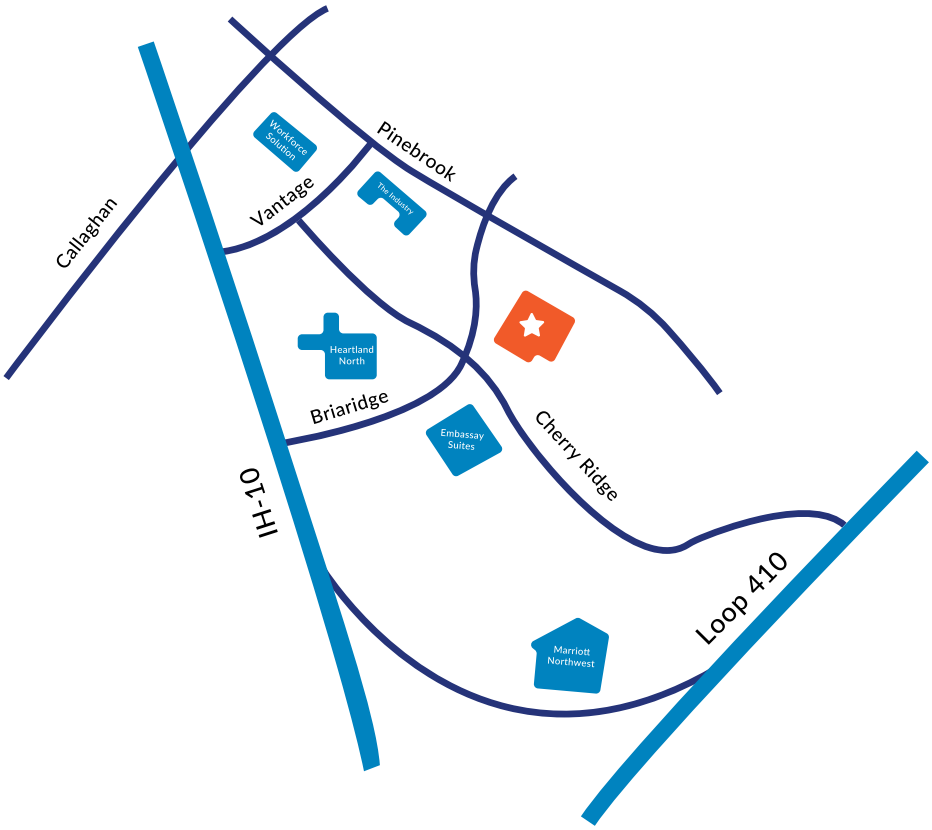
DIRECTIONS TO OUR OFFICE



FROM 281 take 410 West to the Vance Jackson / Cherry Ridge exit. Stay on the frontage road until you reach Cherry Ridge. Turn right on to Cherry Ridge and continue until you see Conroy Square. Turn right into Conroy Square and keep driving parallel with Cherry Ridge. We are located in the West Court breezeway, Suite 216.

FROM HWY 90 take 410 East to the Cherry Ridge exit. Stay on the frontage road until you reach Cherry Ridge. Turn left on to Cherry Ridge a and continue until you see Conroy Square. Turn right into Conroy Square and keep driving parallel with Cherry Ridge. We are located in the West Court breezeway, Suite 216.

FROM BOERNE take IH-10 towards downtown to the Callaghan exit. Exit Callaghan and stay on the frontage road until you reach Callaghan. Turn left on to Callaghan, then take the first right on to Pinebrook and another right onto Briaridge. Turn left into Conroy Square. We are located in the West Court breezeway, Suite 216.

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