TRACEY TABOR WILLIAMS, DMD
Family Dentistry in Lockerbie Square

Tracey Tabor Williams, DMD
303 N. Alabama Street, Suite 270
Indianapolis, IN 46204
317-637-4636
https://www.drtraceywilliams.com

New Patient Form

Please fill out all the information to the best of your knowledge. All answers will be kept confidential. If you have any questions, please ask us, and we'll be happy to assist you.	Date: / /	Patient #:

Patient Information

First Name:	Middle Name:	Last Name:

Sex:	Date of Birth (mm/dd/yyyy): / /	Marital Status:	Social Security #: - -

Home Phone: - -	Cell Phone: - -	E-mail Address:

Home Address:	City:	State:	ZIP Code:

Student Status:	School Name (if a full-time student):

Please tell us where you heard about us (check all that apply):

Friend or Relative (name): Our Website Search Engine (Google, etc.)

Was our website a factor in your decision to visit our practice? Yes No

Name of Spouse (or Parent, if a minor):	Spouse/Parent's Employer:	Spouse/Parent Work Phone: - -	Spouse/Parent Cell Phone: - -

Person Responsible for Account

Title:	First Name:	Middle Name:	Last Name:	Relationship to Patient:

Social Security #: - -	Driver's Licence State & #:	Holder of Dental Insurance for Patient:

Home Phone: - -	Work Phone: - -	Cell Phone: - -	E-mail Address:

Billing Address:	City:	State:	ZIP Code:

Employment:	Employer's Name:	Occupation:

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Insurance Information

Primary Insurance

Insurance Holder's Name:	Date of Birth (mm/dd/yyyy): / /	Relationship to Patient:	Employer:

Member ID:	Group ID:	Insurance Company Name:	Insurance Company Phone: - -

Insured's SSN:	Insurance Company's Address:	City:	State:	ZIP Code:

Secondary Insurance

Insurance Holder's Name:	Date of Birth (mm/dd/yyyy): / /	Relationship to Patient:	Employer:

Member ID:	Group ID:	Insurance Company Name:	Insurance Company Phone: - -

Insured's SSN:	Insurance Company's Address:	City:	State:	ZIP Code:

Authorization

All of the above information is correct to the best of my knowledge. I authorize use of this form on all my insurance submissions and I authorize the release of information to all my insurance companies. I understand that I am responsible for my bill. I authorize Tracey Tabor Williams, DMD to act as my agent in helping me to obtain payment from my insurance companies. I authorize payment to Tracey Tabor Williams, DMD. I permit a copy of this authorization to be used in place of the original. I give Tracey Tabor Williams, DMD, its employees, and/or other agents express prior consent to contact me at any/all phone numbers, including cell numbers (by phone call or text message) and email addresses, for the purpose of treatment, insurance, or payment.

Signature (Type your name to sign electronically, or print and sign):	Date (mm/dd/yyyy): / /

Consent for Treatment

Patient Name:

I hereby authorize the doctor or designated staff to take X-rays, study models, photographs, and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the dental needs of the above-named patient.

Upon such diagnosis, I authorize the doctor or designated staff to perform all recommended treatment mutually agreed upon by us and to employ such assistance as required to provide proper care.

I agree to the use of anesthetics, sedatives, and other medications as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

I have read, understood, and agree to the above treatment policy.

Signature (Type your name to sign electronically, or print and sign):	Date (mm/dd/yyyy): / /

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Payment

Does the person responsible for the account already have an account with this office? Yes No

Payment Method

Notice: Payment is due at the time of service unless alternative arrangements have been made in advance. Please choose a method of payment below.

Cash

Check

Credit Card	Type:	Credit Card Number:	Expiration: /	Card Verification Code: VISA/MC/Discover: 3-digit code printed on back AmEx: 4-digit code printed on front
	Your credit card information is kept on file for outstanding account balances.			

Dental History

Previous Dentist

Dentist Name:	Dental Practice Name:

Last Dental Visit

Last Dental Visit (m/y):
/

Dental Hygiene

Do you brush your teeth? If yes, how often?	Do you floss? If yes, how often?

Today's Visit

Do you have any dental problems, pain, or discomfort at this time? If yes, please describe:

What is the main reason for your visit today?
Tooth Pain Check-up Cleaning Whitening

What would you like to learn more about?
Please Explain:

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Office Policies and Financial Agreement

It is our policy to have a definite agreement between you, the patient, and this office concerning the payment of fees for services rendered. Prior to treatment, you will be advised of the approximate cost. For convenience, we accept Cash, Check, Visa, MasterCard, & Care Credit. All emergency dental services or any dental service performed without previous financial arrangements with the financial staff must be paid for at the time of service.

Patients Not Covered By Dental Insurance: Payment in full is expected when services are rendered.

Patients Covered By Dental Insurance: We will be happy to complete the necessary forms for your dental claims as a courtesy to you. You are responsible for the entire balance regardless of your insurance coverage. We are a third party providing dental services to you and your family. This office requires that you are responsible for your co-payment and deductibles at the time of service. We will allow 60 days for your insurance earner to reimburse us for services provided. If you insurance carrier fails to issue reimbursement within that time frame, the outstanding balance will be your responsibility and a statement will be sent.

Time: We realize that everyone's time is valuable. We reserve your dental appointment just for you and we request that IF the need arises and you have to reschedule an appointment, please provided us with a minimum of 48 hour notice. This would allow us time to contact another patient in need of dental treatment. Failure to notify us in a timely manner or not keeping your scheduled appointment may assess a $50.00 fee.

In consideration for the professional services rendered to me, I agree to pay for those services in full. I agree that a $10.00 late fee per month can be added to any account balance that is over 90 days. In the event that my account is turned over to a collection agency, I agree to pay any court costs and attorney fees which may be associated with my account. I grant my permission for you to telephone me at home or work to discuss matters related to this form.

I HAVE READ AND UNDERSTAND THE ABOVE FINANCIAL AND OFFICE POLICY AGREEMENT.

Signature (Type your name to sign electronically, or print and sign):	Date (mm/dd/yyyy): / /