

Welcome to the office of Dr. Derrick L. Williamson. We sincerely appreciate you choosing our office for your dental and oral health care needs. Please be assured that we will work hard to continually earn the trust that you have placed in us. In order for us to serve you better, please take several minutes to complete this information form as thoroughly as possible.

## Please tell us about yourself

Patient's Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Email Address: \_\_\_\_\_

Who may we thank for referring you to us for care? \_\_\_\_\_

**If the patient is a minor, please tell us about you, the parent or guardian:**

Your Name: \_\_\_\_\_

Your Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Today's Date: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Sex: M F

Social Security #: \_\_\_\_\_

Do you have dental insurance? Yes No

Relationship to Patient: \_\_\_\_\_

Your Home Phone: \_\_\_\_\_

Your Social Security #: \_\_\_\_\_

## Employer Information

Employer Name: \_\_\_\_\_

Employer Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Business Phone: \_\_\_\_\_

Your Position: \_\_\_\_\_

How long with company? \_\_\_\_\_

## Spouse Information

Spouse's Name: \_\_\_\_\_

Spouse's Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Spouse's Employer: \_\_\_\_\_

How long has your spouse been employed at his/her current company? \_\_\_\_\_

Spouse's Soc. Sec. #: \_\_\_\_\_

Spouse's Date of Birth: \_\_\_\_\_

Business Phone: \_\_\_\_\_

## Insurance Information

Name of Insurance Co: \_\_\_\_\_

Name of Insured Person: \_\_\_\_\_

Social Security Number of Insured Person: \_\_\_\_\_

Plan Name or Number: \_\_\_\_\_

Group No./Effective Date: \_\_\_\_\_

Insured Date of Birth: \_\_\_\_\_

**AUTHORIZATION for TREATMENT:** This is to certify that I, the undersigned Patient or Guardian, consent to all medical procedures agreed to between myself and Dr. Derrick L. Williamson, including the use of local, inhalational, sedative or general anesthesia as indicated, and I will assume complete responsibility for all fees associated with those procedures. I agree that all fees are due and payable, in full, at the time services are rendered. The office of Dr. Derrick L. Williamson, at its discretion, may elect to assess me finance charges, not to exceed 1.5% per month, on any balances that are over 60 days past due.

\_\_\_\_\_  
**Patient's (Guardian's) Signature**

\_\_\_\_\_  
**Date**