

McLEMORE DENTISTRY, LLC
RESTORATIVE, COSMETIC, & IMPLANT DENTISTRY

5740 CARMICHAEL ROAD, MONTGOMERY, AL 36117

PHONE (334) 277-9570 FAX (334) 277-0152

EMAIL: DRMCLEMOREDMD@GMAIL.COM WEBSITE: WWW.DRMCLEMOREDENTISTRY.COM

New Patients:

Please return this completed Patient Information Forms along with a copy of both sides of your dental and medical insurance cards ASAP (at least 2 days before your appointment) so that we may be prepared for your visit. Mail, or Fax: 334-277-0152, or Email: drmclemoredmd@gmail.com. Email cell phone photos of your cards.

Patient Information

Date: ___/___/___

Patient Name: _____ (_____)

Last First Middle Preferred Name

Male female Family Status: single married widowed divorced separated child

Social Security # _____ - _____ - _____ Birth Date ___/___/___ Age ___ Driver License # _____

Phone (Home): (____)-____-____ (Work): (____)____-____ Ext: _____ Best Time to Call: _____ am pm

Cell Phone: (____)-____-____ Fax: (____)-____-____ Email: _____ @ _____

Are you using Social Media? yes no Facebook Twitter Instagram Other _____

Home Street Address: _____ Apartment #: _____

City: _____ State: _____ Zip Code: _____

Person to contact in case of an emergency and the person you give us permission to discuss your care:

HIPPA Compliant Name: _____

Phone: (____)____-____ Relationship to you: _____

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

Another Patient Friend Relative Dental Office TV Yellow Pages Internet Other

Please explain: _____

Spouse or Responsible Party Information

The following is for: the patient's spouse parent or legal guardian the person responsible for payment

Last Name: _____ First Name: _____ Middle: _____

Male Female Married Single Divorced Widowed

Social Security # _____ - _____ - _____ Birth Date: ___/___/___

Phone Home: (____)-____-____ Work: (____)-____-____ Ext.: _____ Best Time to Call: _____

Employment Information

The following is for: the patient the person responsible for payment

Employer Name: _____ Your Occupation: _____

How long employed: _____ [] Months/ [] Years Work hours: _____

Street Address: _____ City: _____ State: _____ Zip Code: _____

Dental Insurance Information

Primary Dental Insurance Name: _____

Dental Insurance Company / Plan : _____ Effective Date: ____/____/____

Name of Insured: (as on your insurance card): _____ Is the Insured a patient in our office? Yes No

Insured's Birth Date: ____/____/____ ID #: _____ Group #: _____ SS#: _____

Insured's Employer: _____ City _____ State: _____

Patient's relationship to insured: Self Spouse Child Other: _____

Secondary Dental Insurance (Note; Many Secondary Dental Plans do not pay the same as if they are Primary)

Secondary Dental Insurance Company / Plan : _____ Effective Date: _____

Name of Insured: (as on your insurance card): _____ Is the Insured a patient in our office? Yes No

Insured's Birth Date: ____/____/____ ID #: _____ Group #: _____ SS#: _____

Insured's Employer: _____ City _____ State: _____

Patient's relationship to insured: Self Spouse Child Other: _____

Health Information

List Daily Rx Medications / Prescriptions

Medication or Prescription / Dosage	Reason for the Medication or Prescription
1.	1.
2.	2.
3.	3.
4.	4.
5.	5.
6.	6.
7.	7.
8.	8.
9.	9.
10.	10.
11.	11.
12.	12.

Rx Explanation if needed: _____

MEDICAL HISTORY: Have you ever had any of the following? Please check those that apply:

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Drug Addictions | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Stomach Problems |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Major Surgery | <input type="checkbox"/> Recent Steroid Rx's |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Acid Reflux Disease | <input type="checkbox"/> Fear of Dentists | <input type="checkbox"/> Methytrexate Rx | <input type="checkbox"/> TMJ jaw problems |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Mouth Injuries | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Fosomax, Boniva, etc | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Take Aspirin Daily |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Growths, Tumors, | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Take Blood Thinners |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Head/Face Injuries | <input type="checkbox"/> Psychiatric Problems | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Heart Disease/Attack | <input type="checkbox"/> Pregnant Now | <input type="checkbox"/> Codeine Allergy |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Valve Problem | Due date: _____ | <input type="checkbox"/> Penicillin Allergy |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis A, B, C | <input type="checkbox"/> Respiratory Problems: | <input type="checkbox"/> Anesthetic Allergy |
| <input type="checkbox"/> Diet controlled | <input type="checkbox"/> Hospitalizations | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Snoring/Sleep Apnea |
| <input type="checkbox"/> Medication Rx | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Sinus Problems | Allergies Please List Below |
| <input type="checkbox"/> Take Insulin | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Smoker | |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Kidney Disease | | |

Have you been admitted to a hospital or needed emergency care during the past two years? Yes No

If yes, please explain: _____

• Are you now under the care of a physician? Yes No

If yes, please explain: _____

• Name of Physician: _____ MD City: _____ State: _____

• Do you have any health problems that need further clarification? Yes No

If yes, please explain:

Dental Health Information

Reason for today's visit: Exam Emergency Consultation Explain: _____

Are you experiencing dental pain today? No Yes How long have you been in this pain? _____

Please check those that apply:

<input type="checkbox"/> Discomfort, clicking, or popping jaw	<input type="checkbox"/> Ringing in Ears	<input type="checkbox"/> Difficulty Chewing
<input type="checkbox"/> Red, swollen, bleeding gums	<input type="checkbox"/> Broken/Chipped Tooth	<input type="checkbox"/> Embarrassed to Smile
<input type="checkbox"/> Sensitive tooth, teeth, gums	<input type="checkbox"/> Stained Teeth	<input type="checkbox"/> Would like Whiter teeth
<input type="checkbox"/> Blisters/Sores in or around the mouth	<input type="checkbox"/> Locking Jaw	<input type="checkbox"/> Pain upon chewing
<input type="checkbox"/> Lost/Broken Fillings	<input type="checkbox"/> Bad Breath	<input type="checkbox"/> Use Smokeless tobacco
<input type="checkbox"/> Teeth grinding		<input type="checkbox"/> Smoke

My Concerns about Dental Treatment are : Fear Finances Time

Date of Last Dental Visit: _____ Reason for last dental visit: _____

Date of Last Complete Mouth or Panoramic Dental X-rays: _____ Date of Last Cleaning: ___/___/___

Previous Dentist Name: _____ City: _____ State: _____

Have you ever had any complications following dental treatment? Yes No

If yes, please explain: _____

How would you rate your dental health? Select a number _____ (worst) 1 2 3 4 5 6 7 8 9 10 (best)

Are you financially dependent on your dental insurance plan to pay for any dental work you will need?

Yes NO

Are you interested in applying for a monthly payment Plan (CareCredit)? Yes NO

How can we help you with your dental needs?

Please explain:



Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed. Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. As your Dentist, I want to provide you with the best care possible. There are services that I feel are necessary for the treatment of your condition and maintenance of good health that are not covered by your dental insurance benefits contract. You are expected to pay for those services in full. Let me reassure you that I will order only treatments that I feel are necessary for your dental health and care. In addition, some services may be recommended by me for cosmetic and more personalized results and reasons. If you have any questions about whether or not a particular service is covered by your dental benefits contract, someone in our office will be happy to assist you. Thank you for your understanding. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied. I understand that the fee estimate listed for this dental care can only be extended for a period of two months from the date of the patient examination. In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or conditions I further agree to pay all costs and reasonable attorney fees associated with any collection efforts if law suit is instituted hereunder. I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form. I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I understand that dentistry is not an exact science and no guarantees or assurance of the outcome or results of treatment or surgery can be made or implied. I understand that excessive smoking, alcohol, or sugar; and poor oral hygiene and not following my doctor's home care instructions may affect my healing and may limit the success of my dental treatment. I also give my permission for any photographs, images, x-rays, or models to be taken and used by Dr. Thomas Williams for the advancement of dentistry. I understand that I am responsible for all costs and payment for professional services rendered. This Contract shall be governed by the laws of the State of Alabama. Venue shall be proper in Montgomery County, Montgomery, Alabama.

I understand that if for any reasons my account becomes delinquent, I agree to pay all late charges, interest, collections costs, and reasonable legal fees. I accept the fee charged as a legal and lawful debt and agree to pay said fee, including any/all collection agency fees (33.33%), attorney fees and/or court costs if necessary. I agree that Dr. Clark McLemore and/or their agents may contact me by telephone at any telephone number associated with my account, including wireless telephone numbers, which could result in a charges to me. I agree that you may also contact me by sending text messages or emails, using any emails address I have provided. Methods of contact may include using pre-recorded/artificial voice messages and/or use of automatic dialing device if applicable. I hereby authorize any release of any information, including the diagnosis and records of treatment to my insurance company, or other doctor's offices as requested. I have been given a copy of this office's HIPPA privacy policies. After an initial examination, a written estimate for the recommended dental treatment will be given, and financial arrangements along with risks, benefits and alternative treatments will be discussed at that time. I understand that most financial payment plans require a routine credit assessment and do hereby give my permission in order to help make my dentistry more affordable.

I request and authorize Dr. McLemore and/or staff to provide dental services and fully understand that during, and following the contemplated procedure, surgery, or treatment, conditions may become apparent which warrant, in the judgment of the doctor, additional or alternative treatment pertinent to the success of comprehensive treatment. I agree the type of anesthesia and/or sedation Dr. McLemore chooses, and agree not to operate a motor vehicle or hazardous device for at least 12 hours or more until fully recovered from the effects of sedation or the anesthesia or drugs given for my care.

I have read the above conditions of treatment and payment and agree to their content.

Signature: _____

Date: ____/____/____

CANCELLATION / BROKEN APPOINTMENT POLICY

Our dental practice operates by appointment only. We reserve specific amounts of time to provide our patients with the highest quality dental care and services. Our office utilizes Demand Force; an appointment reminder text messages and emails service, to better serve our patients. We respectfully require 24-hour notice for cancellation or rescheduling of your confirmed reserved dental appointment.

A MINIMUM OF \$50 WILL BE CHARGED TO YOUR ACCOUNT FOR LAST MINUTE CANCELLATIONS, BROKEN APPOINTMENTS, OR NO SHOWS for dental hygiene cleaning and exam visits except in the case of medical or family emergencies. If you do not show for your confirmed cleaning appointment, your hygienists will not have a patient for that hour!

BECAUSE OF LAB COSTS, SURGICAL AND IMPLANT COSTS, SET-UP COSTS, AND MAJOR AMOUNTS OF RESERVED DOCTOR TIME, WE REQUIRE PREPAYMENT OF COPAYS AND FEES AT THE TIME OF SCHEDULING. LAST MINUTE CANCELLATIONS, BROKEN APPOINTMENT, OR NO SHOWS will result in a forfeiture of those payments unless in the case of a medical or family emergency.

“Running late”, or “too busy at work”, or “just forgetting” are not valid excuses.

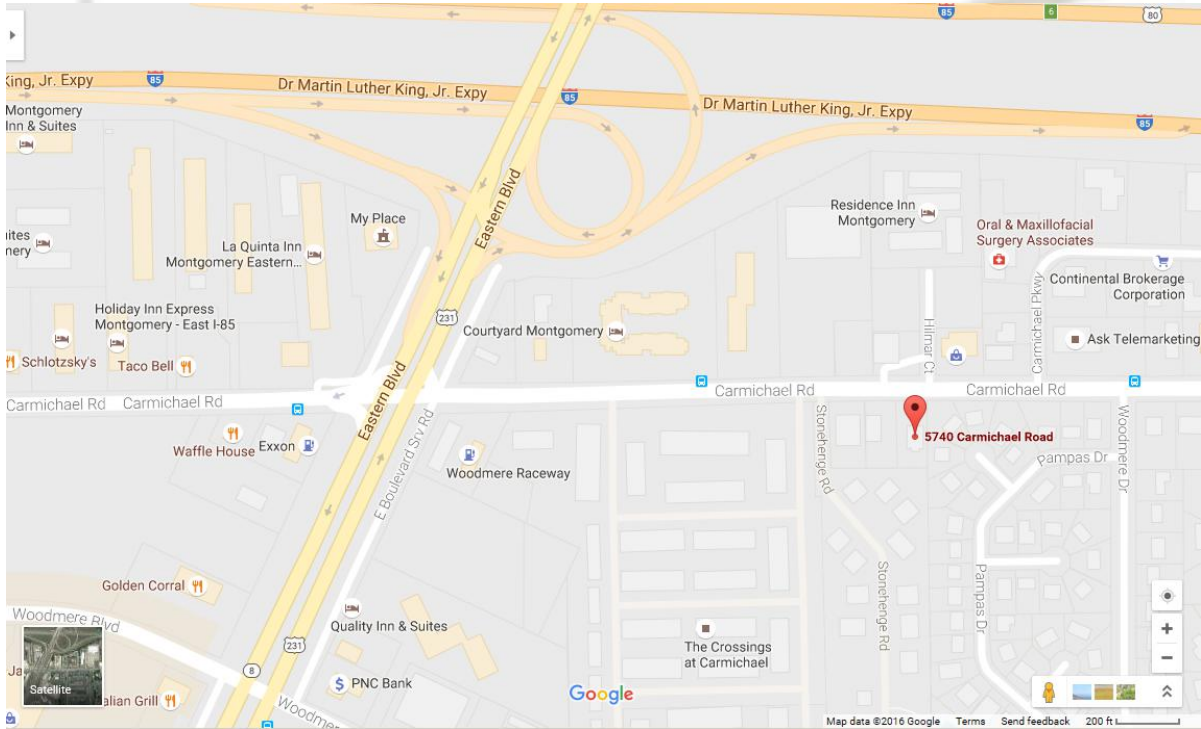
I understand and agree to the above Cancellation/Broken appointment policies.

Required Patient Signature

____/____/____

Date

Map to our Office
McLEMORE DENTISTRY
RESTORATIVE, COSMETIC, & IMPLANT DENTISTRY
5740 CARMICHAEL ROAD, MONTGOMERY, AL 36117
PHONE (334) 277-9570 FAX (334) 277-0152
EMAIL: OFFICE@THWILLIAMS.COM WEBSITE: WWW.THWILLIAMS.COM



Directions: Turn at the Light, at Eastern Blvd going East on Carmichael Road, we are located across the street from Wilson Office Supply.