PATIENT INFORMATION

DR. J WHITLEY WILLS
DR. RACHEL REEDY

PERSONAL INFORMATION

Full Name : _____ **Today's Date** : _____

Date Of Birth : ____ / ____ / ____ **Gender** : ☐ Male ☐ Female

Address : _____

Phone Number : _____ **E-Mail** : _____

Do you prefer text or email reminders? : ☐ Text ☐ Email

Driver's License # : _____ **Social Security #** : _____

Status : ☐ Single ☐ Married ☐ Divorce ☐ Student

Occupation : _____ **Employer**: _____

Whom may we thank for referring you or how did you hear about our office? : _____

EMERGENCY CONTACT DETAILS

Contact Name : _____

Relationship : _____ **Mobile Number** : _____

PHARMACY INFORMATION

Pharmacy Name : _____ **Phone Number** : _____

Address : _____

PRIMARY INSURANCE

Insurance Company : _____ **Insurance Company Telephone #** : _____

Account Holder : _____ **Date Of Birth** : _____

Address : _____

Phone Number : _____ **ID Number or SS Number** : _____

Group Number : _____ **Responsible Party Employed By** : _____

I am aware that shceduled apointments require at least a 24 hour cancellation notice or a $50 no show fee will be added to my account _____ INITIAL

It is very important to be on time for shceduled appointments. Being late may result in being rescheduled along with a $50 cancellation/no show fee _____ INITIAL

Scans, impressions, etc. for labs will not be sent until initial payment is made _____ INITIAL

Date: _____ **Signature** _____

MEDICAL HISTORY

DR. J WHITLEY WILLS
DR. RACHEL REEDY

PHYSICIAN INFORMATION

Physician Name : _____ **Phone #** : _____

Address : _____

Date last seen : _____ **Reason** : _____

Have you seen any other physicians and/or specialists in the last 2 years? ☐ Yes ☐ No

If yes, please provide name, phone number, and reason for seeing

_____

_____

MEDICAL HISTORY

CHECK ALL CONIDITONS YOU HAVE OR HAVE HAD :

- ☐ ALLERGIES/HIVES/HAY FEVER
- ☐ ANEMIA
- ☐ ARTHRITIS, RHEUMATISM
- ☐ ARTIFICIAL HEART VALVE
- ☐ ARTIFICIAL JOINTS (KNEES, HIPS, ETC.)
- ☐ ASTHMA
- ☐ BLEEDING ABNORMALLY
- ☐ BLOOD DISEASE/CLOTTING ISSUES
- ☐ BRUISE EASILY
- ☐ CANCER
- ☐ CHEMICAL DEPENDENCY
- ☐ CONGENITAL HEART DISEASE
- ☐ COUGH
- ☐ CPAP MACHINE
- ☐ DIABETES
- ☐ EMPHYSEMA
- ☐ EPILEPSY OR SEIZURES
- ☐ FAINTING OR DIZZY SPELLS
- ☐ GLAUCOMA
- ☐ HEADACHES
- ☐ HEART MURMUR
- ☐ HEART DISEASE
- ☐ HEART ATTACK
- ☐ HEMOPHILIA
- ☐ HEPATITIS
- ☐ HIGH OR LOW BLOOD PRESSURE
- ☐ KIDNEY DISEASE
- ☐ LIVER DISEASE
- ☐ LUPUS
- ☐ MITRAL VALVE PROLAPSE
- ☐ NERVOUSNESS/ANXIETY
- ☐ PACEMAKER
- ☐ PSYCHIATRIC TREATMENT
- ☐ RESPIRATORY DISEASE
- ☐ RHEUMATIC FEVER
- ☐ SCARLET FEVER
- ☐ SEXUALLY TRANSMITTED DISEASE
- ☐ SINUS ISSUES
- ☐ SICKLE CELL DISEASE
- ☐ STROKE OR BRAIN INJURY
- ☐ THYROID PROBLEMS
- ☐ TOBACCO USE
- ☐ TONSILLITIS
- ☐ TUBERCULOSIS
- ☐ OTHER: _____

Do you have a history of radiation or chemotherapy treatment? ☐ Yes ☐ No

Do you have a history of bisphsphonate therapy? ☐ Yes ☐ No

Have you had any surgeries? (cosmetic included) ☐ Yes ☐ No

Have you ever had a blood transfusion ☐ Yes ☐ No

If yes, please explain (dates, etc.): _____

_____

WOMEN ONLY:

Are you pregnant? ☐ Yes ☐ No

Are you nursing? ☐ Yes ☐ No

Are you on birth control? ☐ Yes ☐ No

MEDICATION AND ALLERGIES

Please list any medications you are currently taking , the reason and the dosage/frequency:

_____

_____

_____

_____

Are you allergic to any medication? ☐ Yes ☐ No **If yes, please list:** _____

Do you have any other allergies? ☐ Yes ☐ No **If yes, please list:** _____

Date: _____ **Signature:** _____

DENTAL HISTORY

DR. J WHITLEY WILLS
DR. RACHEL REEDY

DENTAL HISTORY

What is the reason for your visit today? _____

Date of last dental visit: _____ **Date of last dental x-rays:** _____

CHECK ALL CONIDITONS YOU HAVE OR HAVE HAD :

- ☐ BAD BREATH
- ☐ BLEEDING GUMS
- ☐ CLICKING OR POPPING JAW
- ☐ FOOD DEBRIS BETWEEN TEETH
- ☐ GRINDING TEETH OR CLENCHING
- ☐ LOOSE TEETH OR BROKEN FILLING
- ☐ PERIODONTAL TREATMENT OR "DEEP CLEANINGS"
- ☐ SENSITIVTY WHEN BITING
- ☐ SENSITIVITY TO COLD/HOT
- ☐ SORES
- ☐ ULCERS
- ☐ OTHER: _____

Are you having any pain or discomfort at this time? ☐ Yes ☐ No

Have you ever needed pre-medication (antibiotic) for dental treatment? ☐ Yes ☐ No

Do you feel pain to any of your teeth? ☐ Yes ☐ No

Do you have any sores or lumps in or arround your mouth? ☐ Yes ☐ No

Have you had any head, neck, or jaw injuries? ☐ Yes ☐ No

If yes to any of the above, please explain: _____

Have you had any oral surgeries (including wisdom teeth extraction)? ☐ Yes ☐ No

If yes, please explain and provide the date: _____

Have you had any orthodontic treatment? ☐ Yes ☐ No

If yes, please explain and provide the date: _____

Have you had any prolonged bleeding after dental work? ☐ Yes ☐ No

Have you had any adverse reactions to dental anesthesia? ☐ Yes ☐ No

Are you allergic or have you reacted adversely to any of the following medications below? (PLEASE CIRCLE WHICH IF YES) ☐ Yes ☐ No

ASPRIIN
NITROUS OXIDE
LOCAL ANESTHETIC
SULFA DRUGS
PENICILLIN
PERCOCET
IBUPROFEN
ACETAMINOPHEN
VALIUM
HYDROCODONE
OTHER MEDICATIONS: _____

YOUR SMILE

Are you happy with your smile? ☐ Yes ☐ No

Are you interested in orthodontic treatment (clear aligners)? ☐ Yes ☐ No

Are you interested in veneers or cosmetic services? ☐ Yes ☐ No

Are you interested in whitening? ☐ Yes ☐ No

If you could change anything about your smile what would it be? _____

Date: _____ **Signature:** _____

TERMS & CONDITIONS

DR. J WHITLEY WILLS
DR. RACHEL REEDY

Please understand that we reserve the right to demand payment in full prior to administering any dental care. We are happy to assist you in the filing of necessary forms and it is a courtesy we extend to our patients to file dental insurance claims for you. Our hope remains that you receive the full benefits of your policy; **however, we cannot guarantee any estimated coverage.** Insurance policies are a contract between the enrollee and the insurance company. Because there are so many different dental plans and their terms change often, we cannot accept responsibility for predicting actual coverage benefits. Therefore, **it is the responsibility of the patient to know his or her own dental coverage.** (Consider checking with your company's Human Resources Department for the details of the policy coverage.) Our patients are directly responsible for all charges. **Our office is in network as a Delta Dental Premiere provider and CIGNA DPPO provider.** We accept ALL dental insurances that allow you to go in or out of network. Every plan is different, if you have any questions we will be happy to help but you may call your dental insurance company for details of your dental insurance.

_____ INITIAL

Our office will allow up to 45 days for your insurance payment to be received. After this period has passed, you will be responsible for the entire unpaid balance.

I hereby authorize J. Whitley Wills Dental Office to charge any unpaid balance on the credit card, debit card, Care Credit Account, HAS or FSA card I have placed on file.

Name on card: _____ **Exp Date:** _____

Card #: _____ **CVV:** _____

Patient Signature _____ **Date:** _____

Payment for the estimated portion of your treatment fee, including any deductibles, will be due at time of service. Any remaining balance after insurance payment has been received will be due in full upon receipt of your statement. (Unless payment arrangements are previously made.)

Payment Options:

Cash or Check: Cash payments for services under $500 are required at the time of service. Treatment fees over $500 may be divided into 2 payments. One-half at the time of service and the second-half at the end of 30 days.

Credit Cards: Arrangements have been made for the acceptance of Visa, MasterCard, Discover & American Express for your convenience. Automatic billing may be setup to take care of any remaining balance after insurance benefits are received.

Care Credit: Special financing option. Flexibility and convenient of a health, wellness & beauty credit card. It's easy to apply and you'll receive an answer almost immediately. No interest if paid within 6 or 12 months with qualifying purchases over $200.

Payment Plan: Patients desiring a monthly payment plan may take advantage of Care Credit. (Subject to qualification) There are no fees or down payments required.

Balances not paid over 45 days from the date of beginning of treatment will be considered overdue and immediately payable regardless of insurance claim status. Late fees may accrue at the rate of $35 per month on all accounts not paid in full with 45 days from the date of beginning of treatment. Accounts not paid with 60 days from the date of beginning of treatment may be turned over to collections at the discretion of the accounts manager. All court costs, attorney's fees, collection fees, and any other fee involved in the collection of the account in collections will be the responsibility of the patient and/or guarantor of the account.

_____ INITIAL

TERMS & CONDITIONS CONTINUED

DR. J WHITLEY WILLS
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The patient and/or guarantor is responsible for payment of all services rendered, regardless of insurance coverage or other third-party liability. The patient and/or guarantor agrees to pay any fees that may be involved in collection of the account, including attorney's fees and court costs, should it become necessary to pursue the account for collection. The patient and/or guarantor agrees that the sole venue for resolving and dispute is in Shelby County Memphis, Tennessee. Tennessee law governs this agreement. This is a binding legal agreement and may only be modified in writing signed by Dr. J Whitley Wills.

You agree, that in order for us to service your account or to collect any amounts you may owe, we and our collection agencies may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We and our collection agencies may also contact you by sending text messages or emails, using any email address you provide to use. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

When we make your appointment, we are reserving a room for your particular needs. We ask that if you must change your appointment, please give us at least 24 hour notice. This courtesy makes it possible to give your reserved room to another patient who would like it.

There is a $50 charge for not showing up for scheduled appointments. Repeated cancellations or missed appointments will result in loss of future appointment privileges.

We feel that our patient's time is valuable. When your appointment is made, a room is reserved, your records are prepared, and special instruments are readied for your visit. Except for emergency treatment for another patient, you can expect us to be prompt. We, of course would appreciate the same courtesy from you.

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Before signing this, be absolutely sure that you have read all of it carefully, and its entirety. Be certain that you clearly understand this legal document.

Date: _____ **Signature:** _____

PATIENT PHOTO RELEASE FORM

DR. J WHITLEY WILLS
DR. RACHEL REEDY

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information.

This release is strictly designated to give permission to J. Whitley Wills, DDS, to use my digital patient photo series. I will allow these photos to be shared with other professionals and patients for educational purposes. Dr. J Whitley Wills will have permission to use these photos in the manner described above unless I request him to no longer use them. A written request form is available to do so. I understand that by allowing Dr. J Whitley Wills to use my photos, he is able to share "before and after" images to educate and explain procedures and possible results of treatment. I understand that I have the option to decline this request, and am not obligated in any way to provide permission to use these photos.

I understand that the photographs, slides, and /or videos will be used as a record of my care, and may be used as stated above for educational purposes in lectures, demonstrations, advertising, professional publications (dental magazines, journals, newspapers) and all social media outlets (websites, Facebook, Instagram, Tik Tok and Twitter).

I further understand that if my photographs are used in any publication or as part of a demonstration my name and face will not be used.

I do not expect compensation, financial or otherwise, for the use of these photographs.

Please mark and sign one of the following:

☐ **I am allowing my photos to be used.**

☐ **I am requesting that my digital photographs not be shared with other professionals of patients.**

Date: _____ **Signature:** _____