



SCOTT E. WILLIAMS DDS
ANDY FUHRIMAN DDS

WWW.ZANESVILLEDENTAL.COM
1100 BRANDYWINE BLVD, BLDG C
ZANESVILLE, OH, 43701
740-454-1167 P
740-454-1358 F

WELCOME !

We are pleased and excited with the opportunity to exceed your expectations for your oral healthcare needs. We are a dental practice devoted to restoring and enhancing the natural beauty of your smile using conservative, state-of-the-art procedures that will result in a beautiful, long lasting smile.

Please assist us in making the most of your visit by completing the supplied forms. This will allow our experienced team to maximize their time and attention with you.

Be sure to ask a member of our staff about the many treatment options available such as:

- IV sedation for nervous patients
- Dental implants
- Orthodontics (Braces and Invisalign®)
- Single visit CEREC crowns
- Wisdom teeth removal
- Veneers and teeth whitening
- Root canal therapy

We look forward to meeting with you!

How did you hear about us?

Did one of our patients refer you? Was it the web page? An advertisement? Please explain



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Health Information

Patient's Name: _____

Reason for today's visit

Date of last dental visit _____

Please mark 'Yes' or 'No' for the following:

- Sensitivity to Hot Yes No
- Sensitivity to cold Yes No
- Sensitivity when biting Yes No
- Gums swollen or tender Yes No
- Bleeding gums Yes No
- Jaw pain Yes No
- Food collects between teeth..... Yes No
- Loose teeth or broken fillings..... Yes No

Are you currently under a physicians care?
(if yes, please explain)

Physician's name

Have you been hospitalized within the last 2 years
(if yes, please explain)

List any medications you are currently taking

Allergies:
 Codeine Penicillin Sulfa Latex
 Local Anesthetics
Other: _____

- Please mark 'Yes' or 'No' for the following:
- AIDS/ HIV Yes No
 - Alcoholism..... Yes No
 - Anemia..... Yes No
 - Arthritis..... Yes No
 - Artificial heart valve Yes No
 - Asthma..... Yes No
 - Bleeding Disorder..... Yes No
 - Blood diseases..... Yes No
 - Blood Pressure..... Yes No
 - Bruise Easily..... Yes No
 - Cancer..... Yes No
 - Chemotherapy..... Yes No
 - Cholesterol..... Yes No
 - Diabetes..... Yes No
 - Drug addiction..... Yes No
 - Emphysema..... Yes No
 - Epilepsy/ Seizures..... Yes No
 - Glaucoma..... Yes No
 - Heart disease/ attack..... Yes No
 - Heart murmur..... Yes No
 - Heart Pacemaker..... Yes No
 - Heart Failure..... Yes No
 - Heart Surgery..... Yes No
 - Hepatitis..... Yes No
 - High Blood Pressure..... Yes No
 - Kidney disease..... Yes No
 - Knee/ Hip/ Joint replacement surgery.... Yes No

Date of Surgery _____

- Any type of implant..... Yes No
- Any type of transplant..... Yes No
- Liver disease..... Yes No
- Mitral valve prolapse..... Yes No
- Pacemaker..... Yes No
- Rheumatic or scarlet fever..... Yes No
- Stroke..... Yes No
- Thyroid problems..... Yes No
- Tuberculosis..... Yes No
- Pregnant Yes No _____
- Nursing..... Yes No
- Birth control Pills..... Yes No
- Use Tobacco.... Yes No _____

Other conditions we should be aware of

Is there anything we can do to make your visit more comfortable? -



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**PROVIDER NOTICE
OF PRIVACY PRACTICES**

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Key Issues

Uses and Disclosures: We use health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive. Continuity of care is part of treatment and your records may be shared with other providers to whom you are referred. Information may be shared by paper mail, electronic mail, fax, or other methods. We may use or disclose identifiable health information about you without your authorization in several situations, but beyond those situations, we will ask for your written authorization before using or disclosing any identifiable health information about you. We may also use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters.)

Your Rights: In most cases, you have the right to look at or get a copy of health information about you. If you request copies, we will charge you only normal photocopy fees. You also have the right to receive a list of certain types of disclosures of your information that we made. If you believe that information in your record is incorrect, you have the right to request that we correct the existing information.

Our Legal Duty: We are required by law to protect the privacy of your information, provide this notice about our information practices, follow the information practices that are described in this notice, and seek your acknowledgement of receipt of this notice. Before we make a significant change in our policies, we will change our notice and post the new notice in the waiting area. You can also request a copy of our notice at any time. For more information about our privacy practices, contact the person listed below.

Complaints: If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact the person listed below. You also may send a written complaint to the U.S Department of Health and Human Services. The person listed below can provide you with the appropriate address upon request. If you have any questions or complaints, please contact:

You may refuse to sign this acknowledgement

I have received and read the Notice of Privacy Practices from the office of Dr. Scott E. Williams and Dr. Andy Fuhriman.

Please print name _____

Signature _____ Date _____



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Consent to Perform Dentistry

1. I understand that any treatment that I may require will be explained to me, I may ask questions, and have answers provided. Upon agreeing to any treatment, I hereby authorize and direct the dentists, Scott E. Williams DDS and Andy Fuhriman DDS, and/or dental auxiliaries of their choice, to perform the following dental treatment including the use of any necessary or advisable local anesthesia, radiographs (x-rays), or diagnostic aids; as well as any of the following:

- A. Preventive hygiene treatment (prophylaxis) and the application of topical fluoride.
- B. Application of plastic "sealants" to the grooves of the teeth.
- C. Treatment of diseased or injured teeth with dental restorations, (fillings and crowns, root canal therapy).
- D. Replacement of missing teeth with dental prostheses (bridges, partial dentures, full dentures, implants).
- E. Removal (extraction) of one or more teeth.
- F. Treatment of diseased or injured oral tissues (hard and/or soft).
- G. Use of sedative drugs to control apprehension and or disruptive behavior.
- H. Treatment of malposed (crooked) teeth and/or oral developmental or growth abnormalities.

2. I understand that there are risks involved in all treatment and hereby acknowledge that these risks will be explained to me, and that I will have an opportunity to ask questions regarding the treatment and the risks of the treatment to be performed.

3. I agree to the use of local anesthesia depending on the judgment of the doctor(s). I understand and have been informed of the risks and complications.

4. There are possible risks and complications associated with the administration of local anesthesia, sedation and drugs. The most common of these are swelling, bleeding, pain, nausea, vomiting, bruising, tingling, prolonged and (extremely rare) permanent numbness of the lips, gums, face and tongue, allergic reactions, hematoma (swelling or bleeding at or near the injection site), fainting, lip and cheek biting resulting in ulceration and infection of the mucosa. I also understand that there are rare potential risks such as unfavorable reactions to medications in respiratory and cardiovascular collapse (stopping of breathing and heart function) and lack of oxygen to the brain that could result in coma or death. I understand and have been informed of the above risks and complications.

5. I recognize that during the course of treatment unforeseen circumstances may necessitate additional or different procedures from those discussed. The doctor(s) will discuss the additional treatment before proceeding with treatment. I therefore authorize and request the performance of any additional procedures that are deemed necessary or desirable to oral health and well being in the professional judgment of the dentist.

6. I also authorize the doctor(s) to use photographs, radiographs, and/or other diagnostic materials and treatment records for the purposes of teaching, research, scientific and general publications.

7. I am advised, and agree, that the success of the dental treatment provided requires adherence to post-operative and postcare instructions provided by the doctor(s). I also agree that regular office visits as scheduled by my dentist and his auxiliaries must be maintained.

8. I hereby state that I have read and understand this consent, and that all questions about the procedures will be answered in a satisfactory manner; and I understand that I have the right to be provided answers to questions which may arise during and after the course of my treatment. I also understand that this consent will remain in effect until such time as I choose to terminate it.

Date: _____ Patient's Name Printed: _____

Name of Parent (or Guardian) if child: _____ Relationship to Patient: _____

Signature: Patient or Parent/Guardian _____