919-942-2154 **919-929-7079**

C. Michael Willock, DDS, PA

Chapel Hill, NC

A Holistic Approach to Oral Health & Wellness

We are pleased to welcome you to our practice! Please take a few minutes to fill out this form as completely as you can. If you have questions, we will be glad to help you.

Name: _____ Ms. _____ Mr. _____ Mrs. _____ Dr. _____
Last First MI

Billing Address: _____

Home Address: _____

E-Mail Address: _____ Is this the preferred contact method? Y _____ N _____

Home Phone: _____ Cell #: _____

Best Place to reach you? _____ Best time to reach you: _____ Do you have dental insurance? ___Y ___N

Date of Birth: _____ Male _____ Female _____ Single _____ Married _____ Widowed _____

Employer: _____ Work #: _____

Social Security #: _____ Drivers License: State of Issue: _____ License #: _____

How did you learn of our office: Friend/Family _____ Holistic Internet _____ Google Search _____

Mercury Free ___ Sign ____Huggins _____ IAOMT _____ Sedation Dentist _____ Chapel Hill Yellow Pages: Book ___ Internet ___

Why did you choose Dr. Willock as a dentist? _____

What is your chief concern you want Dr. Willock to address? _____

Other Family Members seen here: _____

In case of an emergency who should be notified? _____ ____ Relationship: _____

Address: _____ City _____ State _____ Zip _____

Home Telephone number: _____ Cell or work # _____

****

- I authorize the Dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.
- I authorize the release of any information concerning my health care, advice & treatment for the purpose of evaluating And administering claims for insurance benefits.
- I authorize the release of any information concerning my dental health to another dentist as may be necessary.
- I acknowledge the receipt of the office NOTICE OF PRIVACY PRACTICES & Consent for Use & Disclosure of Health Information per the HIPPA laws (Forms are included to be signed).

FULL PAYMENT of ALL treatment is due in Full at the time (day) of service. We offer credit terms with approved credit through CARECREDIT: WWW.CARECREDIT.COM

I certify that the above information is accurate to the best of my knowledge.

_____ Date: _____ Signature

Signature of patient (or parent or guardian if minor under 18 years of age) 1010

MEDICAL AND DENTAL HISTORY *C MICHAEL WILLOCK DDS PA*

Patient Name: _____ **Date of Birth**: _____

How do you describe your physical health? _____ Excellent __ Good ___Fair ___ Poor

Are you under the care of a physician? __Y ___N If yes, please explain: _____

_____

Physician's Name: _____ Phone #: _____

Are you currently taking any prescription or over the counter drugs? ____Y ___ N

Please List all Medicines you are taking: _____

_____

Use the back of this form if you need more space to list the medications

Have you ever had or do you have any of the following conditions or medical problems:

Heart Disease……	Y	N	Diabetes……	Y	N	Drug or Alcohol Abuse ……	Y	N
Heart Murmur ……	Y	N	Thyroid Disease ……	Y	N	Psychological Problems……	Y	N
Heart Surgery ……	Y	N	Cancer……	Y	N	Frequent Severe depression …	Y	N
Heart Attack ……	Y	N	Chemotherapy……	Y	N	Frequent Headaches……	Y	N
High Blood Pressure ……	Y	N	Radiation Therapy ……	Y	N	Fainting……	Y	N
Low Blood Pressure ……	Y	N	Colitis……	Y	N	Ulcers……	Y	N
Mitral Valve Prolapse …..	Y	N	Crohns Disease ……	Y	N	Sinus Problems……	Y	N
Congenital Heart Defect ..	Y	N	Asthma……	Y	N	HIV+/Aids……	Y	N
Blood Disorders ……	Y	N	Emphysema……	Y	N	Hepatitis A……	Y	N
Artificial Valves ……	Y	N	Epilepsy……	Y	N	Hepatitis B……	Y	N
Pacemaker ……	Y	N	Seizures……	Y	N	Hepatitis C……	Y	N
Abnormal Bleeding ……	Y	N	Tuberculosis……	Y	N	Artificial Bones/Joints……	Y	N
Blood Transfusion ……	Y	N	Shingles……	Y	N	Frequent Bronchitis ……	Y	N
Stroke ……	Y	N	Arthritis……	Y	N	Hay Fever……	Y	N
Anémia ……	Y	N	TMJ problems……	Y	N	Fever Blisters……	Y	N
Heart Irregularities……	Y	N	Rheumatic Fever……	Y	N	STD / Venereal Disease……	Y	N
Rapid Pulse ……	Y	N	Arthritis……	Y	N	Food Allergies……	Y	N
Multiple Sclerosis……	Y	N	Frequent Constipation	Y	N	Ringing in Ears……	Y	N
Parkinson's Disease ……	Y	N	Extreme Fatigue……	Y	N	Frequent insomnia……	Y	N
Chronic Fatigue Syndrome	Y	N	Frequent Bad Breath……	Y	N	Confusion or forgetfulness ……	Y	N
Infected Tick Bite/Bites……	Y	N	Infected Cat Scratch……	Y	N	Glaucoma……	Y	N
Candida-Related issues …	Y	N	Jaundice……	Y	N	Frequent Infections……	Y	N

Do you have unusual tremors of the hands or arms? ..... Y N
Do you have numbness or a burning sensation in your mouth or gums? ..... Y N
Do you have "dry mouth"? ..... Y N
Do you have irritability or dramatic changes in behavior? ..... Y N
Do you have "brown or age spots" under your eyes or elsewhere on your skin? ..... Y N
Have you had more colds, flu and other examples of infectious diseases than "normal"? .....Y N
Have you been to many doctors for your health and been told "there is nothing wrong, or it is all in your head"? ..... Y N
Are there any health issues that you have that we have not listed? Y N
Please explain:

Have you been hospitalize in the past 5 years for any reason? ___Y ___N Explain: _____

_____

For women:
Are you currently pregnant or trying to get pregnant? _____ Y _____ No

Con't to page 2

Page 2: Patient Name: _____ Date: _____

Is there any other medical information not included above which you feel we should be informed about? _____ Y _____N

If yes, please explain: _____

What prompted you to seek dental care at this time? _____

How long has it been since your last thorough dental examination? _____

When was your last teeth cleaning? _____ X-rays? _____

Are you missing any teeth? __ Y __ N IF Yes, how many? _____ Cause of loss? _____

Have you had any previous periodontal therapy? _____ Y _____ N If yes, please list the provider and dates:

_____

Have you had any bad experiences in a dental office? _____ Y _____N. If yes, please explain: _____

_____

Would you like to know about conscious oral sedation (sleep dentistry)? _____ Y _____N

Are you troubled with bad breath? _____ Y _____N

Do your gums bleed easily, feel tender or irritated? _____ Y _____N

Are there areas in your mouth where food sticks or get caught? _____ Y _____ N

Do your jaws feel tired or sore? _____ Y _____N

I want fluoride treatments and products _____ Y _____N

Do you experience excessive headaches and /or pain in the next, shoulders or back? _____ Y _____N

Do you experience clicking or popping noises when opening or closing your mouth or When chewing? _____ Y _____N

Are you aware of grinding or clenching your teeth? _____ Y _____N

Do you use any tobacco products? _____ Y _____N

Do you use alcohol? _____Y _____N If so, how much? _____

What, if anything would you do to change the appearance of your teeth? _____

Are you allergic to any of the following medications?

Aspirin	Y	N	Amoxicillin	Y	N	Latex	Y	N
Penicillin	Y	N	Epinephrine	Y	N	Dental Anesthetics	Y	N
Tetracycline	Y	N	Ibuprofen (Motrin)	Y	N	Nickel	Y	N
Erythromycin	Y	N	Codeine	Y	N	Other Metals:		
Keflex	Y	N	Sulfa	Y	N	_____		
Clindamycin	Y	N	Valium	Y	N	_____		

Do you require an antibiotic pre-medication before dental treatment? Y N _____

I acknowledge that all of the above information is accurate to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health.

Signature or Patient or Responsible party: _____ Date _____

Thank You for choosing our office as your dental health care provider. We are committed to your treatment being successful. Please understand that full payment for the services is part of the treatment. We realize that every person's financial situation is different. For this reason we have worked hard to provide a variety of payment options to help you receive the dental care needed to enjoy a healthy confident smile. The following is a statement of our financial terms which are required to be read and signed PRIOR TO TREATMENT. In addition, all patients must complete our medical history forms prior to being seated.

PAYMENT IS DUE IN FULL AT THE TIME OF TREATMENT UNLESS PRIOR FINANCIAL ARRANGEMENTS HAVE BEEN APPROVED BY THE FINANCIAL COORDINATOR.

Explanation of Payment Options

This includes today's visit and all future visits

- *Cash and ATM Debit Cards*
- *Personal Check with valid ID*
- *Visa, Mastercard, Discover, and American Express*
- *Carecredit with approved credit (a special healthcare credit card) (Carecredit accounts have 6 months to pay with 0% interest)*

Fees

Billing Fee: If there is a balance on my account which is over 30 days old, I understand that I will be assessed a billing fee of $10.00 or 1.5% per month (18% APR) per month until paid, whichever fee is greater .

Collection Costs: If a check is returned for any reason or dishonored, your account will be electronically debited for the amount of the check plus a $25.00 processing fee by our bank. If legal collection procedures are begun, there will be a minimum fee of $100.00

Missed Appointments: Appointments are made at ***YOUR REQUEST*** and for your dental health. The appointment time is reserved for you alone. Unless an appointment is canceled 48 business hours Mon – Thurs) prior to the appointment time, our terms are to charge you for the missed appointment at the rate of the normal office visit, no less than $75.00. For appointments 2 hours or more, we may request an appointment reservation deposit which will be applied to the appointment. If you cannot make the appointment and do not give us 48 hours business notice, the deposit will be forfeited.

Insurance

Our office is a fee for service office. We offer as a courtesy to our patients to file their dental insurance claims for them when provided the correct insurance information. All fees are due in full at the time of service and your dental insurance claim will be filed for your insurance company to reimburse you the benefit due per your insurance contract.

Minor Patients

The adult accompanying a minor and the parents (or guardians of the minor) are responsible for full payment at the time of treatment.

Our Goal

Our goal with each patient is to help you enjoy the benefits of good oral health. With the proper care, you will be able to have healthy teeth and gums as well as a healthy and attractive smile. We encourage all of our patients to have oral health cleaning and check-ups every six months as it is easier to correct a small problem than "waiting until it hurts".

I certify that I have read and understand the above information to the best of my knowledge and agree to the above financial terms. If I have a question regarding these terms, I will ask a staff member.

X _____ **Date** _____

Signature of patient or responsible party

Insurance Letter of Understanding

Dear Patient:

On the back of this letter is our *INSURANCE INFORMATION* form that we need you to complete so that we can process your insurance claims accurately.

Please complete the form on the back side of this form and then return it to us, *signed*, so that we can enter your information into our computer accurately so that you can receive your benefits in a timely manner.

Most people do not understand their dental plans: understandably as all insurance plans are written in legalize. As with your car, home or health insurance, you are the insured and the contract relationship is between you and your insurance company. The amount of coverage or benefits that you have contracted for (or your employer as is usually the case) is dependent on the amount of premiums paid by you, or you and your employer. Many times, an insurance company will state the benefits are payable at a "usual and customary rate", however what they really mean is that the benefits paid are payable according to the amount of the premiums paid. Dental insurance companies will quote a percentage of a service that they will pay and this too is a play on words, as what they really means is that they have a set fee for the treatment, however they will never disclose this amount during a phone call or in your contract. We think of insurance as a "coupon" not as 100% payment.

We do not "accept assignment of benefits", and all treatment **is due in full by you**, the patient, **at the time of service.** We will be your insurance advocate and we will process (print & mail) your claims. It is our desire that you receive ALL the benefits that you are entitled to with your plan.

If you have questions, please ask!

By signing below, I acknowledge that I have read, understand and agree that I am responsible for all treatment fees.

_____ Date: _____

Signature of Patient or Responsible Party

HIPAA PRIVACY FORM 1

Notice Of Privacy Practices

Purpose: This form, Notice of Privacy Practices, presents the information that federal law requires us to give our patients regarding our privacy practices. {Note: this form may need to be changed to reflect the dental practice's particular privacy policies and/or stricter state laws.}

We must provide this Notice to each patient beginning no later than the date of our first service delivery to the patient, including service delivered electronically, after April 14, 2003. We must make a good-faith attempt to obtain written acknowledgement of receipt of the Notice from the patient. We must also have the Notice available at the office for patients to request to take with them. We must post the Notice in our office in a clear and prominent location where it is reasonable to expect any patients seeking service from us to be able to read the Notice. Whenever the Notice is revised, we must make the Notice available upon request on or after the effective date of the revision in a manner consistent with the above instructions. Thereafter, we must distribute the Notice to each new patient at the time of service delivery and to any person requesting a Notice. We must also post the revised Notice in our office as discussed above.

C Michael Willock, DDS, PA

861 Willow Drive

Chapel Hill NC 27514

Contact Officer: Gwen Willock, Practice Mgr.

Telephone: 919-942-2154 Fax: 919-929-4166

E-mail: gwen@willockdds.com

Address: 861 Willow Drive, Chapel Hill, NC 27514

C Michael Willock, DDS, PA

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect (MM/DD/YR), and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $10.00 for each page, $25.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. **{You must make your request in writing.}** Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to

receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

C Michael Willock, DDS, PA

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
{Please Print Name}

_____
{Signature}

_____
{Date}

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

C Michael Willock, DDS, PA

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Patient Number: _____ Social Security Number: _____

SECTION B: TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Gwen Willock

Telephone: 919-942-2154 Fax: 919-929-4166

E-mail: gwen@willockdds.com

Address: 861 Willow Drive, Chapel Hill NC 27514

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and heath care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT. Include completed Consent in the patient's chart.

REVOCATION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations. I understand that revocation of my Consent will *not* affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent. Signature: _____ Date:_____

C. Michael Willock, DDS, PA
861 Willow Drive, Ste 1
Chapel Hill NC 27514

Dental Insurance Information

Name of Insured: _____ Sex: Male ___ Female ___

Home Address: _____ Birthday: _____

_____ ID# _____

Patient Information

Patient Name: _____ Birthday _____ Sex: M F

Relationship to Insured: Self _____ Spouse ____ Child _____ Other _____

Full time student: Yes ____ No ____ Name of School _____

Do you have other dental insurance? Yes _____ No _____

Name of Secondary Insurance: _____

Employer Information

Employer: _____ Address: _____

Insurance Company Information

Name: _____ Policy/Group # _____

Claims Mailing Address: _____

Phone # : _____ Fax # _____

Insured / Patient ID# _____

Policy Coverage Information

Date Coverage Began/Begins :_____ Do You Have a Waiting Period? Y N

Maximum Annual Benefit: $ _____ Annual Deductible: $ _____

Crowns are Replaceable Every _____ Years Do you have a missing tooth clause? Y N

Cleanings are payable: 2 times a year or once every 181 days (circle the correct one)

Preventative Coverage _____% Basic Coverage _____% Major Coverage _____%

Continued on back.....

C Michael Willock, DDS, PA

CONSENT FOR DISCLOSURE OF HEALTH INFORMATION

ADDENDUM

Patient Name: _____**Date:** _____

Address: _____

E-Mail: _____

SS #: _____ **Phone #:** _____

Purpose of this Addendum to the Consent for Disclosure of Health Information is to further define who your Health Information can be disclosed to:

_____ I authorize the dental office of C Michael Willock, DDS, PA to mail recare Postcards to me at the above address.

_____ I authorize the dental office of C Michael Willock, DDS, PA to e-mail me Information about appointments, x-rays and other issues regarding my Dental health and treatment.

_____ I authorize the dental office of C Michael Willock, DDS, PA to email my x-rays to referral specialist when necessary.

_____ I authorize the dental office of C Michael Willock, DDS, PA to call my home, work or cell phone numbers and leave messages about upcoming appointments if I am not available to answer the phone. *(No treatment message will ever be mentioned-just appointment info; time & date)*

Listed below are persons and their relationship to me who my health information may be shared or discussed with, *this is not the dental medical Referral specialist that Dr. Willock could confer with about my health:*

Name: _____ Relationship: _____

Phone number: _____ Cell: _____

Name: _____ Relationship: _____

Phone number: _____ Cell: _____

Name: _____ Relationship: _____

Phone number: _____ Cell: _____

Patient Giving Consent Signature: _____