

## Patient Record Update

Please assist us with keeping your account up-to-date with your most current information. All information will be kept confidential.

### Patient Information

Patient Name: \_\_\_\_\_ Preferred Name: \_\_\_\_\_

Title: \_\_\_\_\_ Family Status:  Single  Married  Divorced/Separated  Widowed  Child  
Mr/Ms/Mrs/etc

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

Home Phone: ( \_\_\_\_ ) \_\_\_\_\_ Work Phone: ( \_\_\_\_ ) \_\_\_\_\_ Cell Phone: ( \_\_\_\_ ) \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

The following is for:  self / patient  responsible party / guarantor

Name: \_\_\_\_\_ Preferred Name: \_\_\_\_\_  
Last First M.I.

Employer Name: \_\_\_\_\_ Work Phone: ( \_\_\_\_ ) \_\_\_\_\_

Work Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Please note if there is a change in your dental insurance: \_\_\_\_\_  
Carrier Name Group Number

Person to contact in case of an emergency: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: ( \_\_\_\_ ) \_\_\_\_\_

### Medical History

Name of Physician: \_\_\_\_\_ Office Number: ( \_\_\_\_ ) \_\_\_\_\_

Date of last medical examination: \_\_\_\_\_ Are you currently undergoing any medical treatment? Yes No

Have you been hospitalized within the past five years? If so, why? \_\_\_\_\_

Have you ever been told you need to pre-medicate before dental treatment?  Yes  No

Current Medications (please note reason):

Known Allergies:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

### Dental Update

Please answer the following on a scale from 1 to 10, with 10 being the highest rating:

Where would you rate your current dental health? \_\_\_\_\_

How important is your dental health to you? \_\_\_\_\_

How satisfied are you with the dental treatment you receive at Livery Dental? \_\_\_\_\_

### Smile Characteristics

- Is there anything about your appearance of your teeth that you would like to change?  Yes  No
- Are you self conscious about your smile?  Yes  No
- Have you been disappointed with the appearance of previous dental work?  Yes  No
- If you could whiten your teeth for a cost anyone could afford, would you do it?  Yes  No
- If you could make your teeth straighter, would you?  Yes  No
- If you could close spaces in your teeth, would you?  Yes  No
- If you could have a smile makeover, would you?  Yes  No

### Bite and Jaw Joint

- Do you / would you have any problems chewing gum?  Yes  No
- Do you / would you have any problems chewing bagels or other hard food?  Yes  No
- Have your teeth changed in the last 5 years, become shorter, thinner or worn?  Yes  No
- Are your teeth crowding or developing spaces?  Yes  No
- Do you have more than one bite or do you clench (squeeze) to make your teeth fit together?  Yes  No
- Do you have any problems with sleep or wake up with an awareness of your teeth?  Yes  No
- Do you have problems with your jaw joint? (pain, sounds, limited opening, locking or popping)?  Yes  No
- Do you have tension headaches or sore teeth?  Yes  No

### Tooth Structure

- Are any teeth sensitive to hot, cold, biting or sweets?  Yes  No
- Have you ever had a toothache, cracked fillings, broken, chipped or cracked tooth?  Yes  No
- Do you avoid brushing any part of your mouth?  Yes  No
- Do you feel like your mouth is dry?  Yes  No

### Gum and Bone

- Is there anyone with a history of periodontal disease in your family?  Yes  No
- Have you noticed gum recession in the last 5 years?  Yes  No
- Do your gums bleed when brushing, flossing or eating?  Yes  No
- Have you ever noticed an unpleasant taste or odor in your mouth?  Yes  No
- Have you experienced a burning sensation in your mouth?  Yes  No

### Snore and Apnea

- Are you aware that you snore while you sleep?  Yes  No
- Do you feel tired during the day?  Yes  No
- Has someone told you that you snore or stop breathing while you sleep?  Yes  No
- Do you have high blood pressure?  Yes  No
- If yes, what is your blood pressure \_\_\_\_\_ and what medications are you taking? \_\_\_\_\_

Please check Yes or No:

- |                               |  |                           |  |
|-------------------------------|--|---------------------------|--|
| Allergies to Amoxicillin      | <input type="checkbox"/> Yes <input type="checkbox"/> No | Allergies to Codeine      | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Allergies to Local Anesthesia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Allergies to Erythromycin | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Allergies to Aspirin          | <input type="checkbox"/> Yes <input type="checkbox"/> No | Allergies to Fluoride     | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Allergies to Ibuprofen	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Heavy Salivation	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Allergies to Latex	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hepatitis A, B or C _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Allergies to Metals	<input type="checkbox"/> Yes	<input type="checkbox"/> No	High Anxiety	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Allergies to Other	<input type="checkbox"/> Yes	<input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Allergies to Penicillin	<input type="checkbox"/> Yes	<input type="checkbox"/> No	HIV / AIDS	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Allergies to Sulfites	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Allergies to Tetracycline	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Allergies - Hay Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Low Blood Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Mental Disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Nervous Disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Artificial Heart Valve	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Oral Bisphosphonates	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Artificial Joints	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Pacemaker	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Previous Infective Endocarditis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Blood Disease / Hemophilia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Radiation Treatment	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Blood Transfusions	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Respiratory Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Rheumatic / Scarlet Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Chemotherapy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Sinus Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Chest pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Stomach Problem	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cold Sores	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Congenital Heart Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Thyroid Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
COPD	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Tumors	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Dizziness	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Ulcers	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Epilepsy or Seizures	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Are you pregnant?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Excessive Bleeding	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, how many months? _____		
Fainting	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Do you use Tobacco?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Gag Reflux	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, what type and frequency? _____		
Glaucoma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Do you drink Alcohol?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Heart Murmur	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, how much? _____		

All of the information given is accurate to the best of my knowledge. I understand that it is my responsibility to inform Dr. Brian R. Adams of any changes in my health.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Reviewed by: \_\_\_\_\_

### Medical History Future Revisions

1. Changes in the above information:  Yes  No *If yes, please ask for a new medical update form.*

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

2. Changes in the above information:  Yes  No *If yes, please ask for a new medical update form.*

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

3. Changes in the above information:  Yes  No *If yes, please ask for a new medical update form.*

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

4. Changes in the above information:  Yes  No *If yes, please ask for a new medical update form.*

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# Consent For Services & Office Guidelines

## Financial & Insurance Guidelines:

It is our goal to provide you with leading edge dental technologies, the finest dental materials, and expert team in a comfortable environment.

In order to provide this quality of dental care, we require all of our patients to pay their estimated personal cost of treatment at the time of their visit. As a courtesy to our patients, we will file your dental insurance claims with the dental insurance company for the treatments you receive. However, in the event the insurance company, for any reason does not pay the estimated portion of the bill, the balance will become the patient's responsibility and will be billed directly to you.

Please take the time to read and understand your insurance policy and benefits. In most cases, dental insurance is a contract between your employer and a dental insurance company. The benefits you receive are based on the terms of the contract that were negotiated between your employer and the dental insurance company, and not our dental office. Our office will do everything possible to help you understand and make the most of your dental insurance benefits.

Our goal is to help you achieve and maintain optimal dental care. We charge what is usual and customary for our area. For your convenience, we except Cash, Check, Visa/Master Card American Express, Discover and no interest plans with third party financial institutes.

A service charge of 1.5% (18% annual) on the unpaid balance will be charged on all accounts exceeding 30 days, including balances billed to insurance. Any accounts past due over 90 days may be sent to a collection agency. Collection fees will apply.

The treatment fee estimate for dental care can only be extended for a period of three months from the date of patient examination.

## Guidelines for X-rays & Dental Records:

X-rays in conjunction with a clinical exam are necessary for a thorough and accurate diagnosis and dental treatment plan. Examination x-rays are generally taken once a year for adults and every six months for children. However, the frequency at which x-rays are taken will be based upon individual dental need.

## Cancellation Guidelines:

We pride ourselves in providing extra time for the personal attention each patient deserves. Your appointment time in this office will be reserved exclusively for you. In order to continue providing exceptional care in a timely manor, we have set-forth guidelines which we follow for any failed or late notice cancellation appointments. We require 48 hours notice to cancel or change an appointment. We respect your time and make every effort to keep you from waiting but need your help to continue. After the first violation, we will send a letter to you reminding you of the guidelines we have set in place. Should you fail or give late notice of a cancellation a second time your account will be charged \$125.00. After the third violation, in addition to another \$125.00 charge, we will require pre-payment for all future appointments which is non-refundable should you miss or give late notice canceling.

## Proposition 65:

The state of California, under proposition 65, now requires every dentist to give each of their patients a copy of the information relating to materials and techniques used in the dental environment. This information is contained in the attached document entitled "DENTAL MATERIALS FACT SHEET". If you have any questions regarding the information, please feel free to bring your questions to our attention.

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

**I understand that guidelines are subject to change anytime without notice.**

**I have received a copy of the Dental Material Fact Sheet, as required by law.**

**I have received a copy of this practice's Notice of Privacy Practices.**