

Welcome

On behalf of Dr. Brian R. Adams and our Dental Team, we are pleased to welcome you to the 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.
 All information will be kept confidential.

Patient Information

Patient Name: _____ Preferred Name: _____
Last First M.I.
 Title: _____ Gender: _____ Family Status: Single Married Divorced/Separated Widowed Child
Mr/Ms/Mrs/etc M / F
 Date of Birth: _____ SS#: _____ Email: _____
 Home Phone: (____) _____ Work Phone: (____) _____ Cell Phone: (____) _____
 Address: _____ City: _____ State: _____ Zip Code: _____
 Employer Name: _____ Work Phone: (____) _____
 Work Address: _____ City: _____ State: _____ Zip Code: _____
 Person to contact in case if an emergency: _____ Relationship: _____ Phone: (____) _____
 Who may we thank for recommending our office to you? _____

Responsible Party Information

The following is for: Parent/Guardian Self other _____
(If below information is the same as above please leave blank)

Name: _____ Preferred Name: _____
 Title: _____ Gender: _____ Driver's License #: _____
Mr/Ms/Mrs/etc M / F
 Date of Birth: _____ SS#: _____ Email: _____
 Home Phone: (____) _____ Work Phone: (____) _____ Cell Phone: (____) _____
 Address: _____ City: _____ State: _____ Zip Code: _____
 Employer Name: _____ Work Phone: (____) _____
 Work Address: _____ City: _____ State: _____ Zip Code: _____

Dental Insurance Information

Primary Dental Insurance: Yes No

Insured Name: _____

DOB: _____ SS#: _____

Address: _____

City: _____ State: _____ Zip: _____

Employer: _____

Employer Address: _____

City: _____ State: _____ Zip: _____

Patient Relationship to Insured: _____

Insurance Company / Plan: _____

Insurance Address: _____

City: _____ State: _____ Zip: _____

Secondary Dental Insurance: Yes No

Insured Name: _____

DOB: _____ SS#: _____

Address: _____

City: _____ State: _____ Zip: _____

Employer: _____

Employer Address: _____

City: _____ State: _____ Zip: _____

Patient Relationship to Insured: _____

Insurance Company / Plan: _____

Insurance Address: _____

City: _____ State: _____ Zip: _____

Dental History

Name of previous dentist: _____ Date of last exam: _____

Reason for transferring dentist: _____

What is the most important thing about your initial dental visit: _____

Are you aware of any un-treated dental problems? If so, please explain: _____

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 comfortable are you with dental treatment? _____

Personal Dental History

Have you had an unfavorable dental experience? Yes No

Have you ever had complications from past dental treatment? Yes No

Have you ever had trouble getting numb or reactions to local anesthetics? Yes No

Did you ever have braces, orthodontic treatment or had your bite adjusted? Yes No

Have you had any teeth removed? Yes No

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

Have you ever whitened your teeth? 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 replace metal fillings with tooth colored restorations, would you? Yes No

If you could repair chipped teeth, would you? Yes No

If you could replace missing teeth, would you? Yes No

If you could replace discolored / metal crowns with porcelain crowns, 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

Do you wear or have you worn a bite appliance? Yes No

Tooth Structure

Have you had any cavities within the past three years? Yes No

Have you ever had root canal therapy? Yes No

Have you ever had extractions or other oral surgery procedures? Yes No

Do you have a dry mouth? Yes No

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

Gum and Bone

Have you ever been diagnosed or treated for periodontal (gum) disease? Yes No

Have you ever experienced gum recession? Yes No

Is there anyone with a history of periodontal disease in your family? Yes No

Do your gums bleed when brushing, flossing or eating? Yes No

Are your teeth becoming loose? 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

Do you have any dental implants? Yes No

Have you ever had or been recommended to have a deep cleaning? Yes No

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): Yes No

Known Allergies: Yes No

Please check "yes" or "no":

Allergies to Amoxicillin Yes No
Allergies to Local Anesthesia Yes No
Allergies to Aspirin Yes No
Allergies to Codeine Yes No
Allergies to Erythromycin Yes No
Allergies to Fluoride Yes No
Allergies to Ibuprofen Yes No
Allergies to Latex Yes No
Allergies to Metals Yes No
Allergies to Other Yes No
Allergies to Penicillin Yes No
Allergies to Sulfites Yes No
Allergies to Tetracycline Yes No
Allergies - Hay Fever Yes No
Anemia Yes No
Arthritis Yes No
Artificial Heart Valve Yes No
Artificial Joints Yes No
Asthma Yes No
Blood Disease / Hemophilia Yes No
Blood Transfusions Yes No
Cancer Yes No
Chemotherapy Yes No
Chest pain Yes No
Cold Sores Yes No
Congenital Heart Disease Yes No
COPD Yes No
Diabetes Yes No
Dizziness Yes No
Epilepsy or Seizures Yes No
Excessive Bleeding Yes No
Fainting Yes No

Gag Reflex Yes No
Glaucoma Yes No
Heart Murmur Yes No
Heavy Salivation Yes No
Hepatitis A, B or C _____ Yes No
High Anxiety Yes No
High Blood Pressure Yes No
HIV / AIDS Yes No
Kidney Disease Yes No
Liver Disease Yes No
Low Blood Pressure Yes No
Mental Disorder Yes No
Nervous Disorder Yes No
Oral Bisphosphonates Yes No
Pacemaker Yes No
Previous Infective Endocarditis Yes No
Radiation Treatment Yes No
Respiratory Problems Yes No
Rheumatic / Scarlet Fever Yes No
Sinus Problems Yes No
Stomach Problem Yes No
Stroke Yes No
Thyroid Disease Yes No
Tuberculosis Yes No
Tumors Yes No
Ulcers Yes No
Are you pregnant? Yes No
If yes, how many months? _____
Do you use Tobacco? Yes No
If yes, what type and frequency? _____
Do you drink Alcohol? Yes 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: _____

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.

Signature of Patient/Responsible Party

Date