

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.

Gender: _____ Family Status: Single Child

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 other _____
(If below information is the same as above please leave blank)

Name: _____ Preferred Name: _____

Gender: _____ Driver's License #: _____

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: _____
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: _____

Patient's 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): Yes No
Known Allergies: Yes No

Please check "yes" or "no":

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

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 necessity.

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