ADC Dental Clinic

CONFIDENTIAL

(Please Print)

Name_____ Birthdate_____ Home Phone_____
First MI Last

Address_____ City_____ State/ PROV._____ ZIP/ P.C._____

E-mail_____ Cell Phone_____

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Patient's or Parent/Guardian's Employer_____ Work Phone_____

Business Address_____ City_____ State/ Prov._____ Zip/ P.C._____

Spouse or Parent/Guardian's Name_____ Employer_____ Work Phone_____

If Patient is a student, name of school / College_____ City_____ State/ Prov._____

Whom may we thank for referring you?_____

Person to contact in case of emergency_____ Phone_____

RESPONSIBLE PARTY

Name of person responsible for this account_____ Relationship to patient_____

Address_____ Home Phone_____

E-mail_____ Cell Phone_____

Driver's License #_____ Birthdate_____

Employer_____ Work Phone_____

Is this person currently a patient in our office? ☐ Yes ☐ No

INSURANCE INFORMATION

Name of Insured_____ Relationship To Patient_____

Birthdate_____ SS #/SIN_____ Date Employed_____

Name of Employer_____ Work Phone_____

Address of Employer_____ City_____ State/ Prov._____ ZIP/ P.C._____

Insurance Company_____ Group #_____ Union or Local #_____

Ins. Co. Address_____ City_____ State/ Prov._____ ZIP/ P.C._____

1. I hereby certify that the above information is accurate and will be relied upon for granting credit and providing dental service. I understand that I am financially responsible for the charges not covered by or paid for by my insurance for whatever reason.
2. By signing below, I understand that you may verify and exchange information on me and any additional applicants, including requiring reports from credit reporting agencies.
3. I hereby authorize payment directly to the dentist of the group insurance benefits otherwise payable to me. I understand that I am financially responsible for any charges not covered by this authorization. I authorize release of any information relating to any dental claim or claims.
4. I understand that ADC Dental provides business support services to independent dentists and recognize that this dental practice is owned and operated by an independent dentist. I acknowledge that each dentist is individually responsible for the dental care provided to me and no other dentist nor ADC Dental is responsible for my dental treatment.

X_____ Date_____

SIGNATURE OF PATIENT OR PARENT/GUARDIAN IF MINOR

GENERAL HEALTH INFORMATION

ADC Dental Clinic

DATE:_____

PATIENT NAME:_____ BIRTH DATE:____ AGE:_____
LAST FIRST

DENTAL HISTORY

1. Are there other conditions of which we should be aware? YES_____ NO_____ If yes, please specify:_____
2. Why are you here today? Check-Up_____ Cleaning_____ Other_____
   Toothache_____ Chief Complaint_____
3. When did you last visit a dentist?_____ 4. What treatment was performed?_____
5. Was the treatment completed?_____ 6. Did you have a cleaning?_____
7. When were dental x-rays taken?_____
8. Have you ever had prolonged bleeding after an extraction? YES_____ NO_____ If yes, please specify:_____
9. Have you had any problems with past dental treatment? YES_____ NO_____ If yes, please specify:_____
10. Do you have symptoms near your ears associated with movement of your lower jaw such as clicking, popping, pain or locking open?
    YES_____ NO_____ If yes, please specify:_____
11. Have you every been diagnosed or treated for TMD (Temporomandibular Joint Dysfunction sometimes called TMJ?)
    YES_____ NO_____ If yes, please specify:_____
12. Do your gums bleed easily? YES_____ NO_____ 13. Do you feel you have bad breath? YES_____ NO_____
14. Are your teeth sensitive to hot or cold? YES_____ NO_____ 15. Would you like your teeth whiter? YES_____ NO_____
16. How old are your existing partials/dentures?_____

MEDICAL HISTORY

1. Are you under a Doctor's care at this time? YES_____ NO_____ If yes, please specify: Dr. Name:_____
   Dr. Ph. #: (_____)_____
2. Are you allergic to penicillin, codeine, local anesthetics, tranquilizers, latex or any other drugs or medicine?_____
3. Are you taking any medications at this time, including birth control? YES_____ NO_____ If yes, please specify:_____
4. (Women) Are you pregnant at this time? YES_____ NO_____ If yes, please specify how many months:_____
5. Are there any other health problems of which we should be advised? Please specify:_____
6. Do you have, or have you had, any of the following?

Please check "YES" or "NO"		Doctor Comments	Please check "YES" or "NO"		Doctor Comments
Artificial Heart Valve	YES ❑ NO ❑		Hepatitis B or C	YES ❑ NO ❑	
AIDS/HIV+	YES ❑ NO ❑		High Bl. Pressure	YES ❑ NO ❑	
Anemia	YES ❑ NO ❑		Jaundice	YES ❑ NO ❑	
Angina	YES ❑ NO ❑		Joint Prosthesis	YES ❑ NO ❑	
Arthritis	YES ❑ NO ❑		Kidney Disease	YES ❑ NO ❑	
Asthma	YES ❑ NO ❑		Latex Allergy	YES ❑ NO ❑	
Bleeding Problems	YES ❑ NO ❑		Liver Problems	YES ❑ NO ❑	
Cancer	YES ❑ NO ❑		Low Bl. Pressure	YES ❑ NO ❑	
Chemo/Rad Therapy	YES ❑ NO ❑		Lung Disease	YES ❑ NO ❑	
Cosmetic surgery	YES ❑ NO ❑		Pacemaker	YES ❑ NO ❑	
Diabetes	YES ❑ NO ❑		Phen-Fen	YES ❑ NO ❑	
Dizzy Spells	YES ❑ NO ❑		Psychiatric Care	YES ❑ NO ❑	
Drug Addiction	YES ❑ NO ❑		Rheumatic Fever	YES ❑ NO ❑	
Emphysema	YES ❑ NO ❑		Sinus Trouble	YES ❑ NO ❑	
Epilepsy	YES ❑ NO ❑		Smoking Tobacco	YES ❑ NO ❑	
Fainting	YES ❑ NO ❑		Stroke	YES ❑ NO ❑	
Glaucoma	YES ❑ NO ❑		Thyroid	YES ❑ NO ❑	
Heart Attack	YES ❑ NO ❑		TMD or TMJ	YES ❑ NO ❑	
Heart Surgery	YES ❑ NO ❑		Tuberculosis	YES ❑ NO ❑	
Heat Murmur	YES ❑ NO ❑		Venereal Disease	YES ❑ NO ❑	
Heart Problems	YES ❑ NO ❑				

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any changes in my health and/or medication. I further certify that I consent to the performing of x-rays and oral examination.

Patient's signature_____ Date_____
for Parent if patient is a minor

Doctor Signature_____

RECALL REVIEW

1. Patient's Signature_____ Doctor's Signature_____ Date_____
2. Patient's Signature_____ Doctor's Signature_____ Date_____
3. Patient's Signature_____ Doctor's Signature_____ Date_____

NOTICE OF PRIVACY PRACTICES ACKNOWLEGEMENT

ADC DENTAL CLINIC
720 BENNETT AVE
MEDFORD OR 97504

I understand that, under the Health Insurance Portability & Accountability Ace of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used, but is not mandatory for me to sign in order to:

*Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly
*Obtain payment from third-party payers
*Conduct normal healthcare operations such as quality assessments and physician certifications

I have been informed by you of our *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given a copy of your *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change it Notice of Privacy Practices from time to tome and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that your restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name:_____

Signature:_____

Relationship to Patient:_____

Date:_____

MAY WE CALL YOUR HOME: YES OR NO
MAY WE CALL YOUR WORK YES OR NO
MAY WE LEAVE MESS AT WORK: YES OR NO

DO YOU AUTHORIZE ANYONE TO ACCESS INFORMATION ABOUT YOUR ACCT OR TREATMENT:

_____

ADC DENTAL CLINIC INC 720 Bennett Ave Medford OR 97504

OFFICE POLICY

ADC Dental Clinic has called your insurance company and received an estimate of your dental benefits. You will be responsible for your total obligation should your insurance benefits result in less coverage than anticipated. We do ask that you pay your portion at each visit. You will be responsible for your deductible and %. **The dentist will most likely do resin fillings on back teeth and your insurance will not pay on the 80% level.** In the event that you have a balance remaining after the insurance payment you will be charged a monthly finance charge of 2% on the balance remaining until paid in full.

It is our policy that all new patients have a full mouth series of x-rays, comprehensive exam and cleaning. Yearly all patients with or without insurance are required to have an exam, x-rays and cleaning. Emergency patients are able to be seen with a limited exam and x-ray. However, if the patient wishes to continue services in our office they must follow the new patient requirement.

We expect our patients to receive a cleaning every 6 months. However, every patient has different needs and we will allow exceptions as long as it is diagnosed by the dentist. Regardless one cleaning per year is mandatory. It is advisable to have a recall exam every 6 months due to the changes that may occur.

In the event you leave our office or you are dismissed there is a $40.00 duplication fee for x-rays. **This is not covered by your insurance and this fee would be charged to you. I understand that I will be responsible for this fee at the time I pick up my records.**

If you miss 2 appointments without a 24 hour notice we reserve the right to dismiss you from our office and a **no show** fee of $25.00 may be charged.

I have read and understand the office policy for ADC Dental Clinic, Inc and the dental providers. I acknowledge that I am responsible to ask any questions regarding my treatment that I do not understand.

Signature:_____

Signature of guardian:_____

Date:_____

GENERAL DENTISTRY INFORMED CONSENT

ADC Dental Clinic

All patients complete 1 through 4 below, and 5 through 10 as needed

1. **EXAMINATION AND X-RAYS**
   I understand that the initial visit may require radiographis in order to complete the examination, diagnosis and treatment plan.
   (*Initials*_____)

2. **DRUGS, MEDICATIONS AND SEDATION**
   I have been informed and understand that antibiotics and analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). They may cause drowsiness and lack of awareness and coordination which can be increased by the use of alcohol or other drugs. I understand that failure to take medications prescribed for me in the manner prescribed may offer risks of continued aggravated infection and pain and potential resistance to effective treatment of my condition. I undertand that antibiotics can reduce the effectiveness of oral contraceptives. (*Initials*_____)

3. **CHANGES IN TREATMENT PLAN**
   I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the Dentist to make any/all changes and additions as necessary. (*Initials*_____)

4. **TEMPOROMANDIBULAR JOINT DYSFUNCTION (TMD)**
   I understand that symptoms of popping, clicking, locking and pain can intensify or develop in the joint of the lower jaw (near the ear) subsequent to routine dental treatment where in the mouth is held in the open position. Although symptoms of TMD associated with dental treatment are usually transitory in nature and well tolerated by most patients, I understand that should the need for treatment arise, then I will be referred to a specialist for treatment, and the cost of which is my responsibility. (*Initials*_____)

5. **FILLINGS**
   I understand that care must be exercised in chewing on fillings during the first 24 hours to avoid breakage. I undertand that sensitivty is a common after effect of a newly placed filling. On some occasions further treatment such as root canal or surgery my need to be performed. (*Initials*_____)

6. **REMOVAL OF TEETH**
   Alternatives to remove have been explained to me (root canal therapy, crowns, and peridontal surgery, etc.) and I authorize the Dentist to remove the following teeth_____and any others necessary for reasons in paragraph #3. I understand risks involved in having teeth removed, some of which are pain, swelling, spead of infection, dry socket, loss of feeling in my teeth, lips, tongue and surrouding tissue (Parasthesia) that can last for an indefinite period of time or fractured jaw. I understand I may need further treatment by a specialist or even hospitalization if complications arise duringor following treatment, the cost of which is my responsibility.
   (*Initials*_____)

7. **CROWNS, BRIDGES, CAPS, VENEERS AND BONDING**
   I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further undertand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realize that the final opportunity to make changes in my new crown, bridge, or cap (including shape, fit, size and color) will be before cementation. It has been explained to me that, in a very few cases, cosmetic procedures may result in the need for future root canal treatment, which cannot always be predicted or anticipated. I uundertand that cosmetic procedures may affect tooth surfaces and may require modification of daily cleaning procedures. (*Initials*_____)

8. **DENTURES – COMPLETE OR PARTIAL**
   I realize that full or par4tial dentures are artificial, constructed of plastic, metal an/or porcelain. The problems of wearing those appliances have been explained to me including looseness, sorenes, and possible breakage. I realize the final opportunity to make changes in my new denture (including shape, fit, size, placement, and color) will be the "teeth in wax" try-in visit. I undertand that most dentures require relining approximately three to twelve months after initial placement. The cost for this procedure is not included in the initial denture fee.
   (*Initials*_____)

9. **ENDODONTIC TREATMENT (ROOT CANAL)**
   I realize there is no guarantee that root canal treatment will save my tooth, and that complications can occur from the treatment, and that occasionally metal objects are cemented in the tooth or extend through the root which does not necessarily affect the success of the treatment. I understand that occasionally additional surgical procedures may be necessary follwing root canal treatment (apicoectomy).
   (Initials_____)

10. **PERIDONAL TREATMENT**
    I undertand that I have a serious condition causing gum inflammation and/or bone loss, and that it can lead to the loss of my teeth. Alternative treatment plans have been explained to me, including non-surgical cleaning, gum surgery, and/or extractions. I understand the success of any treatment depends in part on my efforts to brush and floss daily, receive regular cleaning as directed, follow a healthy diet, avoid tobacco products and follow other recommendations. (Initials_____)

I understand that dentistry is not an exact science and that therefore reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorized. I understand that each Dentist is an individual practitioner and is individually responsible for the dental care rendered to me. I also understand that no other Dentist other than the treating Dentist nor ADC Dental is responsible for my dental treatment. I acknowledge the receipt of and understand post-operative instructions and have been given an appointment date to return.

Signature_____ Date:_____

Doctor:_____ Witness:_____