Adel DENTAL GROUP

Adult Patient Information

Name:_____ Preferred Name:_____

Date of Birth:_____ Social Security Number: _____ Male ☐ Female ☐

Address:_____ City:_____ State:_____ Zip Code:_____

Home Phone:_____ Cell Phone:_____ Work Phone:_____

Email:_____ Previous Dentist:_____ Date of Last Visit:_____

Employer:_____ Employer Address:_____

Spouse/Partner's Name:_____ Cell Phone: _____

Email:_____ Date of Birth:_____ Social Security Number: _____

Employer: _____ Employer Address:_____

Person responsible for payment:_____

Address (if different than home address):_____

THE BIGGEST COMPLIMENT OUR PATIENTS CAN GIVE US IS THE REFERRAL OF THEIR FAMILY AND FRIENDS!

Whom may we thank for referring you?_____ If he/she a patient here? Yes ☐ No ☐

☐ Building sign ☐ Google ☐ Other

☐ Insurance company ☐ Yellow Pages _____

☐ Mailer/Advertisement ☐ Adel Dental Website _____

Emergency Contact Name:_____ Relationship:_____

Phone Number:_____ Alternate Phone:_____

DENTAL INSURANCE INFORMATION

Primary Dental Insurance Information

Subscriber's Name:_____

Subscriber's Birthdate:_____

Subscriber's SSN or Carrier ID:_____

Employer Name:_____

Policy Number:_____

Insurance Company:_____

Insurance Address and Phone:_____

_____

Secondary Dental Insurance Information

Subscriber's Name:_____

Subscriber's Birthdate:_____

Subscriber's SSN or Carrier ID:_____

Employer Name:_____

Policy Number:_____

Insurance Company:_____

Insurance Address and Phone:_____

_____

__Please note:__ Payment is expected at time of services. If you provide proper insurance information, we will file your insurance as a courtesy. However, you are responsible for your account within the limits of our credit policy, regardless of insurance coverage.

Signature:_____

Adel DENTAL GROUP

Adult Medical History

Patient Name:_____

Welcome to Adel Dental Group! We're excited to provide you with the best possible care.
Please know that all medical history provided will be kept complete confidential.

What is the reason for your visit today?_____

Are you currently under a physician's care? Yes ☐ No ☐ _____

Have you ever been hospitalized or had a major operation? Yes ☐ No ☐ _____

Are you currently taking any medications, pills or drugs? Yes ☐ No ☐ List all medications:_____

_____

Are you currently taking any blood thinners? Yes ☐ No ☐ _____

Do you currently take, or have you taken, Redux, Fosamax, Boniva, Acontel or any medication containing bisphosphonates? Yes ☐ No ☐ _____

Are you on a special diet? Yes ☐ No ☐ _____

Do you use tobacco? Yes ☐ No ☐ _____

Are you **allergic** to any of the following?

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Acrylic
☐ Metal	☐ Latex	☐ Sulfa Drugs	☐ Local Anesthetics
☐ Peanuts	☐ Corn	☐ Dairy	☐ Soy

Other allergies not listed? Yes ☐ No ☐ _____

Do you have any allergic or adverse reactions to any medication or any other substance not listed above? Yes ☐ No ☐

_____

WOMEN: Are you – ☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking Oral Contraceptives?

Indicate which of the conditions you current have or have ever had:

☐ AIDS/HIV positive	☐ Cortisone Medicine	☐ Heart Trouble/Disease	☐ Renal Dialysis
☐ Alzheimer's Disease	☐ Diabetes	☐ Hemophilia	☐ Rheumatic Fever
☐ Anaphylaxis	☐ Drug Addiction	☐ Hepatitis A, B, or C	☐ Scarlet Fever
☐ Anemia	☐ Easily Winded	☐ Herpes (Cold Sores)	☐ Shingles
☐ Angina	☐ Emphysema	☐ High Blood Pressure	☐ Sickle Cell Disease
☐ Arthritis/Gout	☐ Epilepsy/Seizures	☐ High Cholesterol	☐ Sinus Trouble
☐ Artificial Heart Valve	☐ Excessive Bleeding	☐ Hypoglycemia	☐ Stomach/Intestinal Disease
☐ Artificial Joint	☐ Excessive Thirst	☐ Irregular Heartbeat	
☐ Asthma	☐ Fainting Spells/Dizziness	☐ Kidney/Liver Problems	☐ Stroke
☐ Blood Disease	☐ Frequent Cough	☐ Leukemia	☐ Swelling of Limbs
☐ Blood Transfusion	☐ Frequent Diarrhea	☐ Low Blood Pressure	☐ Thyroid Problems
☐ Brain Injury/ Concussions	☐ Frequent Headaches	☐ Lung Disease	☐ Tonsillitis
	☐ Genital Herpes	☐ Mitral Valve Prolapse	☐ Tuberculosis
☐ Breathing Problem	☐ Glaucoma	☐ Osteoporosis	☐ Tumors/Growths
☐ Bruise Easily	☐ Hay Fever	☐ Pain in Jaw Joints	☐ Ulcers
☐ Cancer	☐ Hearing Problem	☐ Parathyroid Disease	☐ Venereal Disease
☐ Chemotherapy	☐ Heart Attack/Failure	☐ Psychiatric Care	☐ Yellow Jaundice
☐ Chest Pains	☐ Heart Murmur	☐ Radiation Treatments	☐ Other_____
☐ Congenital Heart Disorder	☐ Heart Pacemaker	☐ Recent Weight Loss	

Additional conditions or information we should know about you:_____

Signature:_____

Date:_____

Adel
DENTAL GROUP

PATIENT AUTHORIZATION FOR SERVICES

I hereby authorize doctor or staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of _____'s dental needs. Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required in providing proper care. I agree to the use of anesthetic and other medications as necessary. I fully understand that using anesthetic agents embodies certain risks, and that I can ask for complete recital of any possible complications.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I _____, acknowledge that I have been made aware of Adel Dental Group's Notice of Privacy Practices. This notice describes how the doctor may use or disclose my protected health information, certain restrictions on the use and disclosure of my health care information, and rights I may have regarding my protected health information.

I hereby grant access to my dental information to the following individual(s):

Person	Relationship
Person	Relationship

PATIENT PAYMENT FOR SERVICES AGREEMENT

Lastly, I agree to be responsible for payment of all services rendered on my behalf or my dependents. I agree that I shall be responsible for any and all expenses incurred at this office, and I understand that payment is due at the time of services, unless other arrangements have been made, regardless if I have insurance. In the event payments are not received by the agreed upon dates, I understand a finance charge of 18% APR may be added to my account.

Adel Dental Group values the time for each appointment scheduled at our office. We appreciate a notification of 48 hours prior to any appointment cancellation. Please be advised, a fee may be applied for cancellations less than 24 hours prior to the scheduled appointment.

TO BE SIGNED AT YOUR VISIT

Signature:_____ Date:_____