Adair Dentistry
J. Allen Adair, DDS ~ Laura B. Adair, DDS

Name Last First Middle: Telephone:
Home:_____
Work:_____
Cell:_____

_____

Address City State Zip

_____ email:_____

****

Personal Information

Birth Place: _____ ( ) Married
( ) Single Driver's License #_____
Birth Date: _____ ( ) Widow(er)
( ) Child Social Security # _____

Occupation: _____

Employer: _____

****

Person Responsible for Account Balance

Name: _____ Address (if different): _____

Relationship to Patient: _____ Phone #: _____ hm _____ cell

****

Dental Insurance

Policy Holder's Name: _____ DOB: _____ SS# _____

Insurance Name: _____ Group #: _____ Ins Phone #: _____

****

Getting To Know You

Why did you select our office? If a referral, please list name. _____
Is another member of your family a patient in our practice? Who? _____
Person to contact for emergency _____ Phone # _____
When was your last dental visit? _____
When was the last time you had a complete series of x-rays taken (20 films)? _____

****

_____

Signature of Patient/Guardian **Relationship** **Date**

If you have dental insurance, we are happy to file the claims for you. Co-pays or payment are due in full the day the services are rendered. If for any reason, your insurance plan does not honor its commitment to pay the estimated rate, then you are responsible for the remaining balance. Unpaid balances after 30 days will be charged monthly interest at the rate of 1.5% (18% APR). Please note that if an appointment is cancelled without 24 hours notice, you will be charged a fee up to 50% of the total cost of the appointment. Thank you for your understanding.

All responses are kept confidential

1. Are you in good health: Y N
2. Has there been a change in your health in the past year? Y N
3. Date of last physical exam _____
4. Name & Phone # of Physician _____
5. Are you under a physician's care for a particular problem? Y N
6. Have you ever had any serious illness, operation, for hospitalization? If so, describe Y N

_____

7. Are you allergic to or made sick by penicillin, aspirin, codeine, latex, or any other drugs or medications? Y N

If so, please list. _____

Check any of the following you have or have ever had

( ) Heart Failure	( ) HIV Positive (AIDS)	( ) Chronic Obstructive Pulmonary Disease
( ) Congenital Heart Disease	( ) Hepatitis A, B, C	( ) Emphysema
( ) Angina Pectoris	( ) High Blood Pressure	( ) Holistic Treatment/Herbs
( ) Tuberculosis	( ) Heart Murmur	( ) Liver Disease
( ) Asthma	( ) Bruise Easily	( ) Yellow Jaundice
( ) Lupus	( ) Blood Transfusion	( ) Heart Valve Reconstruction
( ) Congenital Heart Lesion	( ) Drug Addiction	( ) Allergies or Hives
( ) Fibromyalgia	( ) Hemophilia	( ) Diabetes
( ) Artificial Heart Valve	( ) Venereal Disease	( ) X-ray or Cobalt Treatment
( ) Heart Pacemaker	( ) Cold sores or Fever Blisters	( ) Chemotherapy
( ) Heart Surgery	( ) Ulcers	( ) Cancer, Leukemia
( ) Artificial Joint	( ) Epilepsy or Seizures	( ) Anemia
( ) Mitral Valve Prolapse	( ) Fainting/Dizzy Spells	( ) Rheumatism/Arthritis
( ) Stroke	( ) Nervousness	( ) Cortisone Medication
( ) Kidney Disease	( ) Psychiatric Treatment	( ) Glaucoma
( ) Take Aspirin Daily	( ) Use Oral Contraceptives	( ) Pain in Jaw Joints
( ) Acid Reflux	( ) Sleep Apnea	( ) Osteoporosis

8. List all medications, vitamins, and herbs you are currently taking._____

_____

9. Are you aware of snoring? Y N
10. Have you been diagnosed with GERD (acid reflux)? Y N
11. Have you been diagnosed with sleep disordered breathing? Y N
    If so, do you use a CPAP machine? Y N
12. Have you been informed you have high blood pressure? Y N
13. Do you smoke or use tobacco? Y N
    How much per day? _____
14. If you have an artificial joint
    A.When was it placed? _____
    B.Are you now required to take antibiotics prior to dental treatment? Y N
15. Have you taken any medications to increase bone density? Y N
16. Are you on a special diet? Y N
17. Is there a history of alcohol or chemical dependency that may affect the care we provide you? Y N
18. Have you had any serious problems associated with any previous dental treatment? Y N
19. Do you have any other disease, condition, or problem not list above? Y N

    Please explain. _____
20. For Women Only
    A. Are you pregnant, or could you be pregnant? Y N
    B. Are you nursing? Y N
    C. If you are using Oral Contraceptives, it's important that you understand that antibiotics (& some other medications) may interfere with the effectiveness of oral contraceptives. Please consult with your doctor for guidance.

Consent to Perform Dentistry

I hereby authorize and direct the dentist(s) of Adair Dentistry and/or dental auxiliaries of his/her choice, to perform the following dental treatment or oral surgery procedure(s), including the use of any necessary or advisable local anesthesia, radiographs (x-rays), or diagnostic aids.

A. Preventative hygiene treatment (prophylaxis) and the application of fluoride.
B. Application of sealants to the grooves of the teeth, to prevent decay
C. Treatment of diseased or injured teeth with dental restorations (fillings and crowns).
D. Replacement of missing teeth with dental prosthesis, (bridges, partial dentures, full dentures).
E. Removal (extraction of one or more teeth)
F. Treatment of diseased or injured oral tissues (hard or soft).
G. Use of sedative drugs to control apprehension and/or disruptive behavior.
H. Treatment of malposed (crooked) teeth and/or oral development growth abnormalities.
I. I understand there may be risks involved in any treatment and hereby acknowledge these risks will be explained to me. I will have an opportunity to ask questions regarding the treatment and risk, and I fully understand the same.
J. **Treatment beyond diagnostic and preventative will be outlined and discussed prior to beginning therapy.**

1. I agree to the use of local anesthesia and/or the use of nitrous oxide/oxygen analgesia. Nitrous oxide may occasionally produce nausea and vomiting. I am also aware the nose-piece leaves an indentation or ring around the nose which disappears shortly after the procedure. I understand and have been informed of the above risks and complications.
2. I recognize that during the course of treatment unforeseen circumstances may necessitate additional or different procedures from those discussed. I authorize the performance of any additional procedures from those discussed. I authorize and request the performance of any additional procedures deemed necessary or desirable to achieve optimum oral health.
3. There are possible risks and complications associated with the administration of local anesthesia, sedation, and drugs. The most common of these are swelling, bleeding, pain, nausea, vomiting, bruising , tingling, and numbness of the lips, gums, face and tongue, allergic reactions, hematoma (swelling or infection of the mucosa). I also understand there are rare potential risks such as unfavorable reactions to medications in respiratory and cardiovascular collapse (stopping of breathing and heart function) and lack of oxygen to the brain that could result in coma or death. I understand and have been informed of the risks and complications.
4. I authorize the doctors to use photographs, radiographs, other diagnostic materials, and treatment records for the purposes of teaching, research, and scientific publications.
5. I am advised that the success of the dental treatment provided will require the patient and the parents to follow post-operative and post-care instructions given by the dentist(s). I agree that the success of the treatment requires all post-operative and post-care instructions to be followed and regular office visits as recommended by my dentist must be maintained.
6**. I hereby state I have read and understand this consent form. I understand that I have the right to ask questions which may arise during the course of my treatment**.

I understand this consent will remain in effect until I or the doctor(s) choose to terminate it.
Date: _____

Patients Name: _____

Name of Parent/Guardian: _____

Relationship to Patient: _____

Signature of Patient/Parent/Guardian

_____

Adair Dentistry
J. Allen Adair, DDS ~ Laura B. Adair, DDS
2150 E Hwy 290 ~ PO Box 1262
Dripping Springs, TX 78620
512.858.5243

Adair Dentistry
2150 E Hwy 290 ~ P.O. BOX 1262
Dripping Springs, TX 78620

HIPAA PRIVACY FORM

Patient Name (print): _____ Date of Birth: _____

By signing this consent form, you consent to our use and disclosure of Protected Health Information. Protected Health Information may be used or disclosed in order to treat a patient, obtain payment for services, or to carry out healthcare operations.
Examples:

*Treatment: sending a specimen, impression, prosthesis, etc. To an outside laboratory or giving necessary information for filling prescriptions.
*Payment: filing with your insurance company or third party collection agencies.
*Healthcare Operations: pulling a chart or confirming an appointment.

Signing this consent does not allow the practice to obtain or disclose records to other physicians without a signed authorization for each request. Please refer to Notices of Privacy Practices for a more complete description of such uses and disclosures. This Notice contains a Patient Rights section describing your rights under law. You have the right to review our Notice, locating in the waiting room at the front desk, before signing the consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office. Adair Dentistry provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Privacy Rule, effective April 14, 2003.

Patient understands the following:

*The practice has a Notice of Privacy Practices and the patient has the right to review the Notice prior to signing the consent.
*The practice reserves the right to change the Notice of Privacy Practices.
*The patient has the right to restrict the uses of their information, but the practice is not required to agree to those restrictions.
*The patient may revoke this consent at any time by writing a letter of request to Laura B. Adair, DDS. However, such a revocation shall not affect any disclosure we have already made.
*The practice may condition receipt of treatment upon the execution of this consent.

_____ _____

Patient or legally authorized individual signature **Date** **Time**

_____ _____

Print name is signed on patient's behalf **Relationship (parent, legal guardian, personal representative)**

For Practice Use Only:

_____

_____

_____

_____ _____

Signature of Practice Employee Date

Adair Dentistry
J. Allen Adair D.D.S. & Laura B. Adair, D.D.S.
2150 E Hwy. 290, Dripping Springs, TX 78620
512-858-5243
info@adairdds.com

AUTHORIZATION TO REQUEST or RELEASE DENTAL/MEDICAL INFORMATION

I _____, authorize Adair Dentistry to request or release
(Please print patient name)
all dental and/or medical information including treatment plans and future appointment dates and/or times to the following friends, relatives and/or doctors.

1. _____ Relationship:_____

2. _____ Relationship:_____

3. _____ Relationship: _____

Please check all that apply where we may leave a message for you.

_____ Voicemail
_____Text
_____ At your place of employment

Other: _____

_____ _____
Patient / Guardian Signature Date