

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: _____

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
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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.

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 physicians care for a particular problem? | Y | N |
| 6. Have you ever had any serious illness, operation, for hospitalization? If so, describe | Y | N |
| <hr/> | | |
| 7. Are you allergic to or made sick by penicillin, aspirin, codeine, latex, or any other drugs or medications? If so, please list. _____ | Y | N |

Check any of the following you have or have ever had

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

- | | | |
|--|---|---|
| 8. List all medications, vitamins, and herbs you are currently taking. _____ | | |
| <hr/> | | |
| 9. Do you smoke or use tobacco?
How much per day? _____ | Y | N |
| 10. If you have an artificial joint
A. When was it placed? _____
B. Any episode of infection | Y | N |
| 11. Are you on a special diet? | Y | N |
| 12. Is there a history of Alcohol or Chemical dependency
That may affect the care we provide you? | Y | N |
| 13. Have you had any serious problems associated with any
previous dental treatment? | Y | N |
| 14. Do you have any other disease, condition, or problem not
Listed above?
Please explain. _____ | Y | N |
| <hr/> | | |
| 15. 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. Use of general anesthesia.

J. 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.

K. 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 ~ P.O. BOX 1262
Dripping Springs, TX 78620
(512) 858-5243