Welcome! *So that we may provide you with the best possible care, please complete the enclosed Registration and Medical History Forms. All information is completely confidential.*

Patient Information

Patient Name		
Mailing Address	City State	Zip Code
Home Telephone	E-Mail Address	
Cell Telephone	DOB	SSN#
In case of emergency, contact	Telephone	
If child, complete the following: Parent/guardian Name	SSN#	

Account Information

Person responsible for this account	Relationship to patient
Address (if different from patient)	Telephone
Name of Spouse/Parent	Telephone

Service will be paid by: [ ] Cash [ ] Check [ ] VISA/MasterCard [ ] American Express [ ] Care Credit

Insurance Information

Insured Name	DOB	SSN#
Employer	Address	Telephone
Ins. Co.	Telephone	
Group #	Policy #	ID #

RELEASE / RESPONSIBILITY AND CONSENT STATEMENT

- **I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.**
- **I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims of insurance benefits.**

- **I authorize release of any information concerning my (or my child's) health care, advice and treatment to another dentist, insurance, or third party.**
- **I authorize payment of insurance benefits directly to the dentist.**
- **I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services. I understand I am financially responsible for payment of services not paid, in whole or in part, by my dental care payor.**
- **Payment of dental services provided in this office for myself and my dependents is due and payable at the time services are rendered unless financial arrangements have been made.**
- **I attest to the accuracy of the information on this page.**

Patient or Guardian's Signature ___________________________________ Date ________________

Thank you for choosing us as your dental health care provider. We appreciate your trust in us and we appreciate the opportunity to serve you.

J.MICHAEL ADAME, DDS, P.A.

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Question	Answer	
Who is your primary care provider?	Yes No	If yes
Another Physicians Care?	Yes No	If yes
Have you ever had a serious head or neck injury?	Yes No	If yes
Are you taking any medications, pills, or drugs?	Yes No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	Yes No	
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	Yes No	If yes
Do you use tobacco?	Yes No	If yes
How many packs?		
Do you use E-Cigarettes?	Yes No	
Do you use controlled substances?	Yes No	
Have you received medical advice to take medication prior to dental visits?	Yes No	If yes

Allergies

Are you allergic to any of the following?

Allergy	Answer
Aspirin	Yes No
Penicillin	Yes No
Codeine	Yes No
Acrylic	Yes No
Metal	Yes No
Latex	Yes No
Sulfa Drugs	Yes No
Local Anesthetics	Yes No
Other? ____________________	Yes No

Do you have, or have you had, any of the following?

Condition	Answer	Condition	Answer	Condition	Answer	Condition	Answer
AIDS/HIV Positive	Yes No	Cortisone Medicine	Yes No	Hemophilia	Yes No	Radiation Treatments	Yes No
Alzheimer's Disease	Yes No	Diabetes	Yes No	Hepatitis A	Yes No	Recent Weight Loss	Yes No
Anaphylaxis	Yes No	Drug Addiction	Yes No	Hepatitis B or C	Yes No	Renal Dialysis	Yes No
Anemia	Yes No	Easily Winded	Yes No	Herpes	Yes No	Rheumatic Fever	Yes No
Angina	Yes No	Emphysema	Yes No	High Blood Pressure	Yes No	Rheumatism	Yes No
Arthritis/Gout	Yes No	Epilepsy or Seizures	Yes No	High Cholesterol	Yes No	Scarlet Fever	Yes No
Artificial Heart Valve	Yes No	Excessive Bleeding	Yes No	Hives or Rash	Yes No	Shingles	Yes No
Artificial Joint	Yes No	Excessive Thirst	Yes No	Hypoglycemia	Yes No	Sickle Cell Disease	Yes No
Asthma	Yes No	Fainting Spells/Dizziness	Yes No	Irregular Heartbeat	Yes No	Sinus Trouble	Yes No
Blood Disease	Yes No	Frequent Cough	Yes No	Kidney Problems	Yes No	Spina Bifida	Yes No
Blood Transfusion	Yes No	Frequent Diarrhea	Yes No	Leukemia	Yes No	Stomach/Intestinal Disease	Yes No
Breathing Problems	Yes No	Frequent Headaches	Yes No	Liver Disease	Yes No	Stroke	Yes No
Bruise Easily	Yes No	Genital Herpes	Yes No	Low Blood Pressure	Yes No	Swelling of Limbs	Yes No
Cancer	Yes No	Glaucoma	Yes No	Lung Disease	Yes No	Thyroid Disease	Yes No
Chemotherapy	Yes No	Acid Reflux	Yes No	Mitral Valve Prolapse	Yes No	Tonsillitis	Yes No
Chest Pains	Yes No	Heart Attack/Failure	Yes No	Osteoporosis	Yes No	Tuberculosis	Yes No
Cold Sores/Fever Blisters	Yes No	Heart Murmur	Yes No	Pain in Jaw Joints	Yes No	Tumors or Growths	Yes No
Congenital Heart Disorder	Yes No	Heart Pacemaker	Yes No	Parathyroid Disease	Yes No	Ulcers	Yes No
Convulsions	Yes No	Heart Trouble/Disease	Yes No	Psychiatric Care	Yes No	Venereal Disease	Yes No
Yellow Jaundice	Yes No	Nursing	Yes No	Pregnant	Yes No		

Question	Answer	
Have you ever had any serious illness not listed	Yes No	If yes
Have you gained or lost 10lbs in the last year?	Yes No	If yes

Sleep Disorders

Do you snore?

- ☐ Occasionally
- ☐ Daily

Do you have sleep apnea? If yes, How do you treat it?

Treatment	Answer
CPAP	Yes No
Oral Appliance	Yes No
Other ____________________	Yes No

OFFICE USE ONLY ASA Class I II III

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X

Date:____________

Health Insurance Portability & Accountability Act of 1996 (HIPAA) Patient Consent Form

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected information. I understand that this information can and will be used 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 operation such as quality assessments and physicians certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time 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 you 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: ______________________________