# Adaptive Dental Associates
## OFFICE POLICY AND CONSENT FORM

Welcome to Adaptive Dental Associates. The following are practice guidelines established to ensure the best possible experience for each patient in this practice. We appreciate your consideration of these policies.

**Appointments**
Please be on time for your appointment. In order to honor other existing appointments, we reserve the right to reschedule any patient who arrives more than 15 minutes late for his/her scheduled appointment time. If you are a new patient to the practice, please arrive at least 10 minutes prior to your scheduled appointment time to complete paperwork.

**No Shows**
We request that if at all possible you provide our office with at least 24 hours notice prior to the cancellation of an appointment. We understand that at certain times emergency type situations may arise precluding you from providing appropriate notice. However, if a patient misses three or more appointments without providing an appropriate notification, we reserve the right to discharge that patient from this practice. Also, we reserve the right to charge a $25.00 fee for failure to show for an appointment without canceling-excluding emergency type situations.

**Payment for Office Visits**
Fees for service at our office will be requested at the time of your visit. Additionally, we reserve the right to charge a $25.00 fee for any returned checks.

**Insurance**
Please present proper insurance cards at each appointment. We reserve the right to cancel an appointment if proper insurance cards are not supplied at the appointment.
**We will file your claim for you at *no charge*; however, we ask that your deductibles and your estimated portions be paid as services are rendered. Although we gladly file dental insurance claims, any and all account balances are ultimately your responsibility.**

- Please note for your convenience, we do accept VISA, MasterCard, Discover, Citi Health Card as well as checks and cash.
- If a balance does accrue ***A 1.5% finance charge will be assessed monthly on all overdue balances.*** I understand that if I am delinquent on my obligation to pay Adaptive Dental Associates, then I will be responsible for any late fees, interest charges, court costs, attorney fees, and collection charges should the balance not be paid in due diligence.

**CONSENT:**
I have read and understand all the above information. The undersigned hereby authorizes the Doctor to perform those diagnostic and treatment procedures, including local anesthesia deemed necessary. If I ever have any change in my health or change in my medication, I will inform the Doctor at the next appointment. For insured patients, my signature below authorizes assignment of insurance benefits to the Doctor and authorizes the release of dental records to my insurance company.

Date _____ Signature _____(Patient, Parent or Guardian)

Thank you for taking the time to read and understand these policies. If you have any questions concerning the above information we would be happy to assist you.

# ADAPTIVE DENTAL ASSOCIATES

755 Memorial Parkway, Suite 301

Phillipsburg, NJ 08865

## PATIENT INFORMATION

NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PATIENT OR PARENT'S EMPLOYER _____

BUSINESS ADDRESS _____

CITY _____ STATE _____ ZIP _____

IF PT IS A STUDENT, NAME OF SCHOOL _____

CITY _____ STATE _____

How did you hear about us? _____

E-mail Address _____

## CONFIDENTIAL

BIRTHDATE _____

HOME PHONE _____

WORK PHONE _____

CELL PHONE _____

OTHER _____

CHECK APPROPRIATE SELECTION:

☐ MINOR ☐ SINGLE ☐ MARRIED

☐ DIVORCED ☐ WIDOWED ☐ SEPERATED

## RESPONSIBLE PARTY

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

EMPLOYER _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

RELATIONSHIP TO PATIENT _____

HOME PHONE _____

WORK PHONE _____

CELL PHONE _____

BIRTHDATE _____

SS NUMBER _____

## INSURANCE INFORMATION

NAME OF INSURED _____

INSURANCE COMPANY _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

RELATIONSHIP TO PATIENT _____

BIRTHDATE _____

SS NUMBER _____

GROUP NUMBER _____

INSURANCE PHONE _____

PATIENT NAME _____ PAGE 2

## ADDITIONAL INSURANCE

NAME OF INSURED _____

INSURANCE COMPANY _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

RELATIONSHIP TO PATIENT _____

BIRTHDATE _____

SS NUMBER _____

GROUP NUMBER _____

INSURANCE PHONE _____

## PATIENT MEDICAL HISTORY

PHYSICIAN NAME _____

PHYSICIAN PHONE _____

DATE OF LAST EXAM _____

- ARE YOU UNDER THE CARE OF A PHYSICIAN ☐ YES ☐ NO
- HAVE YOU BEEN HOSPITALIZED IN THE LAST FIVE YEARS ☐ YES ☐ NO
- ARE YOU TAKING MEDICATIONS? INCLUDING OVER THE COUNTER AND PRESCRIPTION. ☐ YES ☐ NO
- DO YOU USE TOBACCO? ☐ YES ☐ NO
- DO YOU USE ALCOHOL? ☐ YES ☐ NO
- DO YOU USE COCAINE OR OTHER DRUGS? ☐ YES ☐ NO
- DO YOU WEAR CONTACTS? ☐ YES ☐ NO
- DO YOU HAVE ANY ALLERGIES? ☐ YES ☐ NO
- ARE YOU ALLERGIC TO LATEX? ☐ YES ☐ NO
- HAVE YOU EVER HAD A REACTION TO ANESTHETIC? ☐ YES ☐ NO

LIST MEDICATIONS

_____
_____
_____
_____
_____
_____
_____
_____
_____

EXPLAIN ANY "YES" ANSWERS FROM ABOVE (except for medications):

_____
_____
_____
_____
_____

WOMEN ONLY:

- ARE YOU PREGNANT ☐ YES ☐ NO
- ARE YOU NURSING ☐ YES ☐ NO
- ARE YOU TAKING BIRTH CONTROL PILLS ☐ YES ☐ NO

PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS ABOUT YOURSELF:

*(MARK ALL ANSWERS WITH A YES OR NO)*

| | YES | NO | | YES | NO | | YES | NO |
|---|---|---|---|---|---|---|---|---|
| HIGH BLOOD PRESSURE | ☐ | ☐ | FREQUENTLY TIRED | ☐ | ☐ | KIDNEY DISEASE | ☐ | ☐ |
| HEART ATTACK | ☐ | ☐ | ANEMIA | ☐ | ☐ | AIDS/HIV INFECTION | ☐ | ☐ |
| RHEUMATIC FEVER | ☐ | ☐ | EMPHYSEMA | ☐ | ☐ | STD'S | ☐ | ☐ |
| SWOLLEN ANKLES | ☐ | ☐ | CANCER | ☐ | ☐ | THYROID PROBLEMS | ☐ | ☐ |
| FAINTING/SEIZURES | ☐ | ☐ | ARTHRITIS | ☐ | ☐ | HEPATITIS A, B OR C | ☐ | ☐ |
| ASTHMA | ☐ | ☐ | JOINT REPLACEMENT | ☐ | ☐ | ULCERS | ☐ | ☐ |
| LOW BLOOD PRESSURE | ☐ | ☐ | CHEST PAINS | ☐ | ☐ | RESPIRATORY PROBLEMS | ☐ | ☐ |
| EPILEPSY/CONVULSIONS | ☐ | ☐ | SHORT OF BREATH | ☐ | ☐ | PSYCHIATRIC PROBLEMS | ☐ | ☐ |
| LEUKEMIA | ☐ | ☐ | STROKE | ☐ | ☐ | | | |
| DIABETES | ☐ | ☐ | HAY FEVER/ALLERGIES | ☐ | ☐ | | | |
| HEART DISEASE | ☐ | ☐ | TUBERCULOSIS | ☐ | ☐ | | | |
| CARDIAC PACE MAKER | ☐ | ☐ | RADIATION THERAPY | ☐ | ☐ | | | |
| HEART MURMER | ☐ | ☐ | GLAUCOMA | ☐ | ☐ | | | |
| ANGINA | ☐ | ☐ | LIVER DISEASE | ☐ | ☐ | | | |

OTHER _____

_____
_____
_____
_____
_____

PATIENT NAME _____



## PATIENT DENTAL HISTORY

| | | |
|---|---|---|
| 1. DO YOUR GUMS BLEED WHILE BRUSHING OR FLOSSING? | ☐ YES | ☐ NO |
| 2. ARE YOUR TEETH SENSITIVE TO HOT OR COLD LIQUIDS/FOODS? | ☐ YES | ☐ NO |
| 3. ARE YOUR TEETH SENSITIVE TO SWEET OR SOUR LIQUIDS/FOODS? | ☐ YES | ☐ NO |
| 4. DO YOU FEEL PAIN IN ANY OF YOUR TEETH? | ☐ YES | ☐ NO |
| 5. DO YOU HAVE ANY SORES OR LUMPS IN YOUR MOUTH? | ☐ YES | ☐ NO |
| 6. HAVE YOU EVER SUFFERED TRAUMA TO YOUR FACE MOUTH OR JAW? | ☐ YES | ☐ NO |
| 7. DOES YOUR JAW EVER CLICK, POP, CRACKLE OR ACHE? | ☐ YES | ☐ NO |
| 8. DO YOU HAVE PAIN IN YOUR JAW JOINT, EAR OR SIDE OF THE FACE? | ☐ YES | ☐ NO |
| 9. DO YOU HAVE DIFFICULTY OPENING OR CLOSING YOUR MOUTH? | ☐ YES | ☐ NO |
| 10. DO YOU HAVE DIFFICULTY CHEWING? | ☐ YES | ☐ NO |
| 11. DO YOU HAVE FREQUENT HEADACHES? | ☐ YES | ☐ NO |
| 12. DO YOU CLINCH OR GRIND YOUR TEETH? | ☐ YES | ☐ NO |
| 13. DO YOU BITE YOUR LIPS OR CHEEKS FREQUENTLY? | ☐ YES | ☐ NO |
| 14. HAVE YOU PROBLEMS WITH PREVIOUS DENTAL WORK? | ☐ YES | ☐ NO |
| 15. HAVE YOU EVER HAD BRACES? | ☐ YES | ☐ NO |
| 16. HOW MANY TIMES A DAY DO YOU BRUSH YOUR TEETH? | _____ | |
| 17. HOW OFTEN DO YOU FLOSS? | _____ | |
| 18. DO YOU USE A MANUAL BRUSH OR ELECTRIC? | _____ | |
| 19. DO YOU USE ANY TYPE OF MOUTH RINSE? | ☐ YES | ☐ NO |

TELL ME WHAT YOU LIKE ABOUT YOUR SMILE: _____

_____

_____

IF YOU COULD CHANGE ANYTHING ABOUT YOUR SMILE, WHAT WOULD THAT BE? _____

_____

_____

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been answered accurately. I understand that providing false or incorrect information can be dangerous to my health.

_____ _____

PATIENT SIGNATURE DATE

_____

PRINT NAME

**Adaptive Dental Associates**
**St. Luke's Professional Plaza**
**755 Memorial Parkway, Suite 301**
**Phillipsburg, NJ 08865**
**Phone: 908-847-4498 Fax: 908-847-0767**

# Authorization to Release Medical Information

Date:_____

Patients Name:_____ D.O.B_____

I,_____, give Adaptive Dental Associates permission to release all medical and dental information from my records to the following family members:

If patient is a minor, this form is to give consent to anyone else other than parents.

Name:_____ Relationship to Patient:_____

Name:_____ Relationship to Patient:_____

Name:_____ Relationship to Patient:_____

Name:_____ Relationship to Patient:_____

Patient/Guardian Signature:_____

Adaptive Dental Assocaites
755 Memorial Parkway, Suite 301
Phillipsburg, NJ 08865

Today's Date _____

Patients Name _____

Address _____

_____

Home Phone _____

Cell Phone _____

Email Address _____

May we contact you by:

| | | | | |
|---|---|---|---|---|
| Home Phone | ☐ | YES | ☐ | NO |
| Cell Phone | ☐ | YES | ☐ | NO |
| Email Address | ☐ | YES | ☐ | NO |

How did you hear about us

☐ Web Search

☐ Mailing

☐ Referred By _____

Signature of patient or
legal guardian _____

Submit