

Adams Morgan Family Dentistry, PLLC

PATIENT INFORMATION FORM

Name _____ Today's Date _____

How do you wish to be addressed? _____

Birth Date _____ Sex _____ Social Security No. _____

Home Address _____

Home Phone _____ Business Phone _____

Mobile _____ E-Mail address _____

Occupation _____ Employed by _____

Business Address _____

Spouse _____ Other family member in this practice _____

Who will pay this account? _____

Mailing address if different from above _____

Who may we thank for referring you? _____

Do you have dental insurance? _____

Dental Insurance Name _____

ID No. _____ Group No. _____

Dental Insurance Phone Number and Mailing Address _____

Subscriber's Name _____ Subscriber's SSN _____

Subscriber's DOB _____

OVER

MEDICAL HISTORY

Patient Name _____ Nickname _____ Age _____

Name of Physician _____

Most recent physical examination _____ Purpose _____

What is your estimate of your general health? Poor Fair Good

HAVE YOU EVER HAD THE FOLLOWING:	YES	NO		YES	NO
1. hospitalization for illness or injury.....	<input type="checkbox"/>	<input type="checkbox"/>	24. stomach or duodenal ulcer.....	<input type="checkbox"/>	<input type="checkbox"/>
2. allergic to			25. digestive disorders.....	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> aspirin, ibuprofen, acetomenophen			26. arthritis.....	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> penicillin			27. glaucoma.....	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> erythromycin			28. contact lenses.....	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> tetracycline			29. head or neck injuries.....	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> codeine			30. epilepsy, convulsions (seizures)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> local anesthetic			31. viral infections and cold sores.....	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> fluoride			32. any lumps or swelling in mouth.....	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> metals (gold, stainless steel)			33. hives, skin rash, hay fever.....	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> latex			34. venereal disease.....	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> any other medications _____			35. hepatitis (type _____).....	<input type="checkbox"/>	<input type="checkbox"/>
3. heart problems.....	<input type="checkbox"/>	<input type="checkbox"/>	36. HIV / AIDS.....	<input type="checkbox"/>	<input type="checkbox"/>
4. heart murmur.....	<input type="checkbox"/>	<input type="checkbox"/>	37. tumor, abnormal growth.....	<input type="checkbox"/>	<input type="checkbox"/>
5. rheumatic fever.....	<input type="checkbox"/>	<input type="checkbox"/>	38. radiation therapy.....	<input type="checkbox"/>	<input type="checkbox"/>
6. scarlet fever.....	<input type="checkbox"/>	<input type="checkbox"/>	39. chemotherapy.....	<input type="checkbox"/>	<input type="checkbox"/>
7. high blood pressure.....	<input type="checkbox"/>	<input type="checkbox"/>	40. emotional problems.....	<input type="checkbox"/>	<input type="checkbox"/>
8. low blood pressure.....	<input type="checkbox"/>	<input type="checkbox"/>	41. psychiatric treatment.....	<input type="checkbox"/>	<input type="checkbox"/>
9. a stroke.....	<input type="checkbox"/>	<input type="checkbox"/>	42. antidepressant medication.....	<input type="checkbox"/>	<input type="checkbox"/>
10. artificial prosthesis (i.e. heart valve or joints)	<input type="checkbox"/>	<input type="checkbox"/>	43. alcohol / drug dependency.....	<input type="checkbox"/>	<input type="checkbox"/>
11. anemia or other blood disorder.....	<input type="checkbox"/>	<input type="checkbox"/>			
12. prolonged bleeding due to a slight cut.....	<input type="checkbox"/>	<input type="checkbox"/>	ARE YOU:		
13. emphysema.....	<input type="checkbox"/>	<input type="checkbox"/>	44. presently being treated for any illness.....	<input type="checkbox"/>	<input type="checkbox"/>
14. tuberculosis.....	<input type="checkbox"/>	<input type="checkbox"/>	45. aware of a change in your general health.....	<input type="checkbox"/>	<input type="checkbox"/>
15. asthma.....	<input type="checkbox"/>	<input type="checkbox"/>	46. often exhausted or fatigued.....	<input type="checkbox"/>	<input type="checkbox"/>
16. sinus problems.....	<input type="checkbox"/>	<input type="checkbox"/>	47. subject to frequent headaches.....	<input type="checkbox"/>	<input type="checkbox"/>
17. kidney disease.....	<input type="checkbox"/>	<input type="checkbox"/>	48. a heavy smoker (1 pack or more a day).....	<input type="checkbox"/>	<input type="checkbox"/>
18. liver disease.....	<input type="checkbox"/>	<input type="checkbox"/>	49. considered a touchy person.....	<input type="checkbox"/>	<input type="checkbox"/>
19. jaundice.....	<input type="checkbox"/>	<input type="checkbox"/>	50. often unhappy or depressed.....	<input type="checkbox"/>	<input type="checkbox"/>
20. thyroid or parathyroid disease.....	<input type="checkbox"/>	<input type="checkbox"/>	51. easily upset or irritated.....	<input type="checkbox"/>	<input type="checkbox"/>
21. hormone deficiency.....	<input type="checkbox"/>	<input type="checkbox"/>	52. FEMALE – taking birth control pills.....	<input type="checkbox"/>	<input type="checkbox"/>
22. high cholesterol.....	<input type="checkbox"/>	<input type="checkbox"/>	53. FEMALE – pregnant.....	<input type="checkbox"/>	<input type="checkbox"/>
23. diabetes.....	<input type="checkbox"/>	<input type="checkbox"/>	54. MALE – Prostate disorders.....	<input type="checkbox"/>	<input type="checkbox"/>

Please describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment _____

List any medications, herbal supplements, and or vitamins taken within the last two years _____

Please advise us in the future of any change in your medical history or any medications you may be taking.

Patient's Signature _____ Date _____

DENTAL HISTORY

Referred by _____ How would you rate the condition of your mouth? Excellent Good Fair Poor
 Previous dentist _____ How long have you been a patient? _____ Months/Years
 Date of most recent dental exam ____/____/____ Date of most recent dental X-Ray ____/____/____
 Date of most recent treatment (other than a cleaning) ____/____/____
 I routinely see my dentist every: 3mo. 4mo. 6mo. 12mo. Not routinely

WHAT IS YOUR IMMEDIATE DENTAL CONCERN? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

YES NO

PERSONAL HISTORY

1. Are you fearful of dental treatment? Scale of 1 to 10 (very) _____
2. Have you had an unfavorable dental experiences?.....
3. Have you ever had complications
4. Have you ever had trouble getting numb or reactions to local anesthetic?
5. Did you ever have braces, orthodontic treatment or had your bite adjusted?
6. Have you had any teeth removed?

SMILE CHARACTERISTICS

7. Is there anything about the appearance of your teeth that you would like to change?
8. Have you ever whitened (bleached) your teeth:
9. Are you self conscious about your teeth:
10. Have you been disappointed with the appearance of previous dental work:

BITE AND JAW JOINT

11. Do you / would you have any problems chewing gum?
12. Do you / would you have any problems chewing bagels or other hard foods?
13. Have your teeth changed in the last 5 years, become shorter, thinner or worn?
14. Are your teeth crowding or developing spaces?.....
15. Do you have more than one bite or do you clench (squeeze) to make your teeth fit together?.....
16. Do you have any problems with sleep or wake up with an awareness of your teeth?
17. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping)
18. Do you have tension headaches or sore teeth?.....
19. Do you wear or have you ever worn a bite appliance?

TOOTH STRUCTURE

20. Have you had any cavities within the past 3 years?.....
21. Do you have a dry mouth?.....
22. Are any teeth sensitive to hot, cold, biting or sweets?
23. Have you ever had a toothache, cracked filling, broken, chipped or cracked tooth?
24. Do you avoid brushing any part of your mouth?.....

GUM AND BONE

25. Have you ever been diagnosed or treated for periodontal (gum) disease?
26. Have you ever experienced gum recession?
27. Is there anyone with a history of periodontal disease in your family?
28. Do your gums bleed when brushing, flossing or eating?
29. Are your teeth becoming loose?
30. Have you ever noticed an unpleasant taste or odor in your mouth?
31. Have you experienced a burning sensation in your mouth?

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

ADAMS MORGAN FAMILY DENTISTRY PAYMENT POLICIES

Below please find our **office payment policies**. Patients must agree to these terms in order to receive treatment. Please read and sign below.

I. The Patient is Responsible for All Costs and Fees

Full payment is expected at the time of service. We accept cash, money order, or credit/debit cards. We do not accept personal checks.

We require a debit or credit card number to be placed on file for charges incurred and not paid by the patient, or the patient's insurance carrier. You authorize Adams Morgan Family Dentistry, PLLC to apply any unpaid fees to your card.

Card# _____ Exp. Date ____/____/____ Sec. Code _____

II. Dental Insurance of Third –Party Payers

If you have dental insurance, we will accept your insurance as payment, and submit a claim to your insurance carrier. You must provide us with the insurance carrier and policy number prior to treatment. Often, insurance pays only a portion of your bill, or you must pay a co-pay. We can only provide you with an **estimate** of how much your insurance carrier will pay. This estimate is not binding on us or you. You, the patient, are responsible for any portion of your bill not paid for by insurance. Any overpayment or excess payment will be refunded.

III. Cancellations

Unlike some offices, we reserve treatment time especially for you. We don't "double book" or book more patients than we can see. Should you need to cancel or change your appointment, you must do so **two business days prior to your appointment**, to avoid our **mandatory cancellation fee of \$50.00**. This cancellation fee will be charged for any missed appointment, or any appointment cancelled later than two business days prior to treatment. This fee must be satisfied before we will schedule a new appointment.

IV. Remedies for Unpaid Fees and Costs

In the event that any patient balance remains unpaid after 30 days, you authorize us to charge your debit or credit card on file. In the event that the balance remains unpaid, we reserve the right to forward any outstanding balance to a collection agency or institute legal action or both. You agree to pay reasonable attorney fees or costs associated with any collection action.

These financial policies help us keep the cost of administering dentistry affordable for you. Please assist us, as a partner in your dental health, by following our policies. Thank you, and welcome to our practice!

I have read and understand this policy and agree to the above terms.

Patient name

Relationship to patient (if a minor)

Signature of patient or responsible party

Date

Caries Risk Assessment Form

Adults/Children Over Age 6

Patient Name: _____ Date: _____

Instructions: Circle the answers that apply.

FACTORS	HIGH	MODERATE	LOW
1 DISEASE FACTORS			
Visible cavitations	yes		no
Cavity in last three years	yes		no
Radiographic lesions	yes		no
White spot lesions	yes		no
2 RISK FACTORS			
Inadequate saliva flow		yes	no
Appliances present		yes	no
Deep pits/fissure	yes	no	
Exposed roots	yes	no	
GERD	yes		no
Sjogren's syndrome	yes		no
Hyposalivary meds	yes		no
Radiation therapy	yes		no
Snacks between meals	> 3 times	1-3 times	infrequent
Regular soda	yes	infrequent	no
Recreational drugs	yes		no
3 PROTECTIVE FACTORS			
Fluoridated water	no		yes
Fluoridated toothpaste	no		yes
Adequate saliva flow	no		yes
Fluoride mouth rinse		no	yes
Xylitol gum/mints		no	yes
CariFree rinse	no	yes	
Other Rx rinse	no	yes	
4 LABORATORY TESTS			
Screening	3500 – 9999	1500 – 3500	0 – 1500
Culture	high	moderate	low
CARIES RISK ASSESSMENT	HIGH	MODERATE	LOW
PROGNOSIS	POOR	FAIR	GOOD

I have been given the recommendation to have a CariScreen and/or CariCult bacterial test to determine my bacterial counts as a part of my overall caries risk assessment. I understand the risks and benefits of the test and I decline, releasing my dentist(s) of any liability associated with declining the test.

Release Signature: _____ Date: _____

*Based on the clinically proven Caries Risk Assessment Form in the Featherstone 2003-2005 study.