R. CLYNE ADAMS, D.M.D. JOEL ADAMS, D.M.D.
509 Fifth Street, S.W.
Cullman, Alabama 35055
(256) 734-1810

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

PATIENT INFORMATION

Sex ❑ M ❑ F

Last Name _____ First Name _____ Preferred Name _____ Middle Initial _____

Address _____ City_____ State _____ Zip _____

Primary Cell _____ Secondary Cell _____ Home _____

Date of Birth _____ Age _____ Soc. Sec. # _____

Marital Status _____ Occupation/Grade _____ Employer/School_____

Email Address_____ Emergency Contact _____ Emergency Phone _____

Whom may we thank for referring you to our office? ❑ Family ❑ Friend ❑ Newspaper ❑ Phone Book ❑ Location ❑ Sign ❑ Other

Guardian or Spouse Information

Spouse

Last Name _____ First Name _____ Middle Initial _____

Address _____ City_____ State _____ Zip _____

Spouse's Primary Phone _____ Secondary _____Work _____

Spouse's Date of Birth _____ Age _____ Soc. Sec. # _____

Guardian _____ Person Responsible for Account _____

PRIMARY DENTAL INSURANCE

Name of Insured _____ Relationship to Patient _____

Date of Birth _____ Soc. Sec. # _____

Name of Employer_____ Employer's Phone _____

Insurance Company _____ Policy/Contract ID # _____ Group # _____

SECONDARY DENTAL INSURANCE

Is Patient covered under additional insurance? ❑ Yes ❑ No If Yes, Please List:

Name of Insured _____ Relationship to Patient _____

Date of Birth _____ Soc. Sec. # _____

Name of Employer_____ Employer's Phone _____

Insurance Company _____ Policy/Contract ID # _____ Group # _____

STATEMENT OF FINANCIAL POLICY

As a service to you, this office offers several means of payment for the services and materials. It is customary to pay the professional fees for the examination and office visits the same day the services are endered. When dental treatment is received, we ask that a 50% deposit be made at the time the materials are ordered with the balance due upon delivery. To ensure that we understand how you want your account handled, please read this statement carefully; check the payment plan which you prefer and sign in the space indicated. If you have questions, please feel free to ask before you make your choice.

❑ Check ❑ Cash ❑ MC/Visa/Discover and ❑ Insurance

Any deductibles or co-payments must be paid at the time of visit.

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered, and I understand that providing incorrect information can be dangerous to my health. I authorize the doctor to release any information including the diagnosis and the records of any treatment or examination rendered to me or my dependents during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the doctor. I agree to be responsible for payment of all services rendered on my behalf or my dependents. There will be a $30 service charge on all returned checks. If my account becomes delinquent, I agree to pay all collection fees.

_____ _____

Signature of Patient, Parent, Guardian Date

R. CLYNE ADAMS, D.M.D. JOEL ADAMS, D.M.D.

HIPPA: NOTICE OF PRIVACY

LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your right concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect **10/02/06**, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right ot make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the New Notice available upon request. You may also request a detailed copy of these policies to keep for your records.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use or disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence of qualifications of healthcare professionals, evaluating practitioner and provider performance, conduction training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an Authorization, you may revoke it in writing at any time. Your revocation will not affect any use of disclosures permitting by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to extend necessary help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identify or locating) a family member, your personal representative or another person responsible for your care, or your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your bet interest.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail message, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing ot obtain access to your health information. Yo may obtain a form to request access by using the contact information listed at the end of the Notice. We will charge your a reasonable cost-based fee for

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means of location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

CONSENT FOR SERVICES

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination. In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to the Doctor at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services will be as billed unless objected to by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I have read the above Hippa Privacy Notice, the conditions of treatment and payment and I do agree to their content.

_____ Date: _____ Relationship to Patient: _____

Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____

Signature of guarantor of payment/responsible

Patient Medical History

Patient Name _____

Physician _____ Office Phone _____ Date of Last Exam _____

Do you take blood thinners? ❑ Yes ❑ No If yes, please explain: _____

Are you under a physician's care now? ❑ Yes ❑ No If yes, please explain: _____

Have you recently been hospitalized? ❑ Yes ❑ No If yes, please explain: _____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ❑ Yes ❑ No

Are you on a special diet? ❑ Yes ❑ No If yes, please explain: _____

Do you smoke or use tobacco? ❑ Yes ❑ No If yes, how often? _____

Do you use controlled substances? ❑ Yes ❑ No If yes, please explain: _____

Do you need to premedicate for dental treatment? ❑ Yes ❑ No If yes, why? _____

Women: Are you:
Pregnant/Trying to get pregnant? ❑ Yes ❑ No Taking oral contraceptives? ❑ Yes ❑ No Nursing? ❑ Yes ❑ No

Are you allergic to any of the following:
❑ Aspirin ❑ Penicillin ❑ Codeine ❑ Local Anesthetics ❑ Acrylic ❑ Metal ❑ Latex ❑ Sulfa Drugs ❑ Red Dye
❑ Other If yes, please explain _____

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

Acid Reflux	Yes	No	Chest Pains	Yes	No	Heart Trouble/Disease	Yes	No	Psychiatric Care	Yes	No
ADD/ADHD	Yes	No	Cold Sores/Fever Blisters	Yes	No	Hepatitis A	Yes	No	Radiation Treatments	Yes	No
Alzheimer's Disease	Yes	No	Congenital Heart Disease	Yes	No	Hepatitis B or C	Yes	No	Renal Dialysis	Yes	No
Anaphylaxis	Yes	No	Coronary Disease	Yes	No	Hemophilia	Yes	No	Rheumatic Fever	Yes	No
Anemia	Yes	No	Developmental Delays	Yes	No	Herpes	Yes	No	Rheumatoid Arthritis	Yes	No
Angina	Yes	No	Diabetes	Yes	No	High Blood Pressure	Yes	No	Scarlet Fever	Yes	No
Arthritis/Gout	Yes	No	Drug Addiction	Yes	No	High Cholesterol	Yes	No	Sinus Trouble	Yes	No
Artificial Heart Valve	Yes	No	Easily Winded	Yes	No	Hypoglycemia	Yes	No	Spina Bifida	Yes	No
Artificial Joint	Yes	No	Emphysema	Yes	No	Irregular Heartbeat	Yes	No	Stomach/Intestinal Disease	Yes	No
Asthma	Yes	No	Epilepsy or Seizures	Yes	No	Kidney Problems	Yes	No	Stroke	Yes	No
Autism	Yes	No	Excessive Bleeding	Yes	No	Liver Disease	Yes	No	Swelling of Limbs	Yes	No
Autoimmune Disorders	Yes	No	Excessive Thirst	Yes	No	Low Blood Pressure	Yes	No	Thyroid Disease	Yes	No
Blood Disease	Yes	No	Fainting Spells/Dizziness	Yes	No	Lung Disease	Yes	No	Tonsillitis	Yes	No
Blood Transfusion	Yes	No	Glaucoma	Yes	No	Mitral Valve Prolapse	Yes	No	Tuberculosis	Yes	No
Breathing Problem	Yes	No	Heart Attack/Failure	Yes	No	Osteoporosis	Yes	No	Tumors or Growths	Yes	No
Cancer	Yes	No	Heart Murmur	Yes	No	Parathyroid Disease	Yes	No	Ulcers	Yes	No
Chemotherapy	Yes	No	Heart Pacemaker	Yes	No	Parkinsons	Yes	No	Venereal Disease	Yes	No

Please explain any "yes": _____

_____

Patient Dental History

Name of Previous Dentist _____ Date of Last Exam _____

Previous Dentist Phone No. _____ Date of Last Cleaning _____

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 to any of your teeth? Yes No
5. Do you have any sores or lumps in or near your mouth? Yes No
6. History of any periodontal therapy? Yes No
7. Do you like your smile? Yes No
8. Do you snore or have you been told that you snore? Yes No
9. Have you ever received oral hygiene instructions? Yes No
10. Have you had any head, neck or jaw injuries? Yes No
11. Do you bite your lips or cheeks frequently? Yes No
12. Have you ever had any difficult extractions in the past? Yes No
13. Have you had any orthodontic treatment? Yes No
14. Do you have dental anxiety? Yes No
15. Have you ever had any prolonged bleeding following extractions? Yes No
16. Do you wear dentures or partials Yes No
    If yes, date of placement _____
17. Do you have frequent headaches/migraines? Yes No
18. Do you clench or grind your teeth? Yes No
19. Have you ever experienced any of the following problems in your jaw?
    - Clicking, popping Yes No
    - Pain (joint, ear, side of face) Yes No
    - Difficulty in opening or closing Yes No
    - Difficulty chewing Yes No

Please turn page to list medications. ⇨

Please list all prescription and over the counter medications including all supplements.

Drug	Drug Strength	Amount/Times Taken Daily	Reason for Medication	Prescriber