Dr. Frank Adams and staff would like to welcome you and your family to Bridge Dental. At Bridge Dental, you will experience an environment of highly personalized attention and service intent on delivering dental care of the highest quality. Our practice is committed to providing the finest available care to achieve your personal dental needs.

Your dental care is Bridge Dental's highest priority. During your initial visit, you will come to recognize the distinct level of professionalism and courtesy from Dr. Adams. After completing a comprehensive exam by Dr. Adams we will develop a detailed personalized treatment plan focused on achieving the best possible outcomes for your dental health. We gladly offer state-of-the-art equipment in a comfortable setting and conveniences such as Nitrous Oxide, wireless headphones and digital radiographs to ensure the most pleasant experience for you.

Please help us prepare for your appointment by filling out the enclosed patient documents which consist of a detailed medical history and a confidential patient information form. Prior to your visit, please provide us with information regarding pre-medications and we will promptly make arrangements with your pharmacy of choice. Should you have any questions or concerns, please contact us at anytime.

Bridge Dental is comprised of qualified professionals who are ready to serve you and your family. We look forward to meeting you at your scheduled appointment.

Welcome to our practice,

Dr. Frank Adams

BRIDGE DENTAL
53 Windermere Blvd.
Charleston, SC 29407
(843) 225-0111

Today's Date: _____

NAME: _____

E-Mail Address**:** _____

I prefer to be called: _____ ☐ Male ☐ Female

Birthdate: ___/___/___ Age: ____ SS#:_____

Home Address: _____

_____

☐Single ☐Married ☐Divorced ☐ Widowed☐ Separated

Hm #: (___ _____ ____Cell #:_____

Wk # :(___)_____Ext: ___ DL#_____

Best way to reach you? (Phone) (Email) (Text)

Best time to reach you? _____

Whom may we thank for **referring** you? _____

Other family members seen by us: _____

Emergency Contact:_____

Phone #:(___)_____Relation_____

Employer:_____

Employer's Address: _____

How Long There? _____ Occupation _____

Previous Dentist: _____

Last Visit Date: _____

Spouse Information

His/Her Name: _____

Employer: _____

Wk #: (___) _____ Ext: ____ SS #:_____

Birthdate: ___/___/___ DL#:_____

Dental Insurance:

Primary Dental Insurance

Insurance Co. Name: _____

Address: _____

Phone #: (___) _____

Insured's Name:_____

Relationship to Patient:_____

Insured's Birthdate: ____/____/__ _____

Insured's ID #:_____Group#:_____

Insured's Employer: _____

Employer's Address: _____

Secondary Dental Insurance

Insurance Co. Name: _____

Address: _____

Phone #: (___) _____

Insured's Name:_____

Relationship to Patient:_____

Insured's Birthdate: ____/____/__ _____

Insured's ID #:_____Group#:_____

Insured's Employer: _____

Employer's Address: _____

Person Responsible for Account:

Name: _____

Phone#: (___)_____WK #: (___)_____

Billing Address: _____

Relationship to Patient: _____

SS#: _____ Birthdate:___/___/_____

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

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.

Are you under a physician's care now? Yes No If yes, please explain: _____
Have you ever been hospitalized or had a major operation? Yes No If yes, please explain: _____
Have you ever had a serious head or neck injury? Yes No If yes, please explain: _____
Are you taking any medications, pills, or drugs? Yes No If yes, please explain: _____
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 _____
Are you on a special diet? Yes No
Do you use tobacco? Yes No
Do you use controlled substances? Yes No

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
Other If yes, please explain: _____

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

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 Problem	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	Hay Fever	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

Have you ever had any serious illness not listed above? Yes No _____

Comments: _____

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 _____ DATE _____

53 Windermere Blvd.
Charleston, SC 29407
(843) 225-0111

Dental History

What brings you to **Bridge Dental**? _____

_____

Are you currently in any pain? (Y)(N) **If yes**, please explain_____

_____

Has fear ever been an issue for you in a dental office? (Y) (N)

Have you ever had a serious/difficult problem associated with any previous dental work? (Y)(N) **If yes**, please explain_____

_____

How would you describe your current dental health?
(Good) (Fair) (Poor)

Have you ever had **orthodontic** (braces) treatment? (Y) (N)
If so, when did you complete treatment? Date: _____

Are your teeth sensitive?
(Hot) (Cold) (Sweets) (Pressure)

Do your gums ever bleed while brushing or flossing? (Y) (N)

How many times a week do you **brush**?_____**Floss**?_____

What type of toothbrush are you currently using?
(Manual) (Electric) (Battery Operated)

Have you ever had **periodontal** (gum) disease? (Y) (N)

Does food or floss catch between your teeth? (Y) (N)

Do you clinch or grind your teeth? (Y) (N)

Do you have any clicking, popping, or discomfort in your jaw? (Y) (N)

Do you participate in any active/recreational activities? (Y) (N)

Do you now, or have you ever experienced pain or discomfort in your jaw (TMJ/TMD)? (Y) (N)

Do you currently wear a night-guard? (Y) (N)

Do you require any pre-medications before dental treatment? (Y) (N)

How do you feel about the appearance of your teeth?

_____

_____

Is time a factor in getting your dental work done? (Y) (N)

Is there any additional information that you would like to share with us to ensure you have a pleasant visit at **Bridge Dental**?

_____

_____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

Patient Signature_____**Date:** _____

OFFICE USE ONLY

I verbally reviewed the Medical and Dental information with the patient named herein.

Initials:_____ **Date:**_____

Updated Health History

Initials:_____ **Date:**_____

Initials:_____ **Date:**_____

Doctor's Comments:

_____

_____

_____

_____

_____

_____

_____

BRIDGE DENTAL – FRANCIS W. ADAMS, DMD

NAME_____ **DATE OF BIRTH**_____

FINANCIAL POLICY FOR PATIENT CARE SERVICES

To help us provide efficient and reasonable dental care service, it is necessary for us to have a Financial Policy. Please initial next to each statement to indicate your understanding and acceptance of our policies.

1. Patients are responsible for the payment of all services provided. (_____) ← *initial here*

2. Discuss your account balance and payment plans with the office administrator, not the Dentist. The office administrator is better equipped to handle questions regarding financial issues. (_____) ← *initial here*

3. Every insurance plan is different, and it is the patient's responsibility to check with their insurance company prior to office visits, radiographs, dental procedures or referral office visits as to what their cost will be. These services are ordered by Dr Adams when indicated to provide optimal care. We are not always aware of what your individual insurance plan covers. There may be additional costs at the time of service. (_____) ← *initial here*

4. If you have insurance, and we are contracted with your carrier, we require that you pay your co-pay, co-insurance and any unmet deductible at the time of service. Since we are not a party to the agreement between you and your insurance company, you will be responsible for any unpaid balance after 30 days from your visit. It is our policy to file insurance claims for you, *as a courtesy.* WE MUST HAVE ACCURATE, COMPLETE and UPDATED INSURANCE INFORMATION AT EACH VISIT. PLEASE PRESENT IT UPON ARRIVAL. (_____) ← *initial here*

5. Patients are responsible for confirming with their insurance company that Francis W. Adams, DMD - Bridge Dental is an "in network" provider at the time of each visit. If insurance does not pay due to network status, the patient remains responsible for any visit charges. (_____) ← *initial here*

6. If you do not have insurance and, therefore, are a self-pay patient, payment for the office visit and all additional services is due IN FULL at the time of service unless arrangements are made in advance of the appointment. (_____) ← *initial here*

7. If your account becomes delinquent requiring submission to a 3rd Party (i.e. collection agency, courts, etc.), $100 or an amount equal to 50% of your balance (whichever is greater) will be accessed to your account prior to submission. This is in addition to any returned check fees ($45) or any other filing fees. (_____) ← *initial here*

8. Transfer of records to another office will take place upon receipt of a signed request and confirmation of no outstanding balance with this office. (_____) ← *initial here*

9. Appointment CANCELLATIONS AND RESCHEDULES are to be made at least 48 business hours prior to appointment time. Failure to do so will result in a $60 per hour no-show fee. Arriving more than 15 minutes late for your appointment will be considered a no-show. Payment of all outstanding no-show fees will be required prior to scheduling another office visit. After 3 no-shows or cancellations with less than 48 business hours notice, we reserve the right NOT to reschedule the patient. (_____) ← *initial here*

PATIENT OR GUARDIAN SIGNATURE:_____ **DATE:**_____

BRIDGE DENTAL

South Windermere Shopping Center
53 Windermere Blvd.
Charleston, SC 29407
843.225.0111
Fax. 843.225.0114

EMAIL bridgedentalassociates@gmail.com

AUTHORIZATION FOR RELEASE OF DENTAL RECORDS

I hereby authorize _____ (Previous Doctor)

_____ (Address)

_____

_____ (Phone)

to furnish radiographs and record of treatment regarding _____(Patient)

Thank you in advance for your prompt attention.

Signed: _____ Date: _____

Relationship to patient (please circle): self parent guardian

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To Be Completed By Dental Office

Date of last visit: _____ Date of last Panorex: _____

Date of last prophy: _____ Date of last full mouth series: _____

Date of last bite wings: _____

www.bridgedentalcharleston.com