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 to 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 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 – 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 payment of all services provided. Discuss balances and financial arrangements with the office administrator, not the Dentist. The office administrator is best equipped to handle these questions. (_____) ← *initial here*

2. Appointment CANCELLATIONS AND RESCHEDULES are to be made at least 48 business hours prior to appointment time. We offer multiple means in which to confirm or change your appointment. Failure to do so may result in a $60 PER HOUR no-show fee. Arriving more than 15 minutes late for your appointment may 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*

3. Financial arrangements are considered binding. The office reserves the right to add a $10.00 per month billing charge on any account in default status. Default status is considered: 1) non-payment of scheduled arrangements; 2) unpaid account balances in excess of 30 days. This office is not responsible to pursue alternate credit cards for Good Faith arrangements. It is the patient's responsibility to contact this office with any changes or updated information. (_____) ← *initial here*

4. 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*

5. 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*

6. 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*

7. 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*

8. 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*

9. 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*

PATIENT OR GUARDIAN SIGNATURE:_____ DATE:_____

BRIDGE DENTAL

PATIENT REGISTRATION

Today's Date: _____

Name: _____

Preferred Name: _____ ☐ Male ☐ Female

Email: _____

Birthdate: __/__/__ Age: _____ SS#: _____

Home Address: _____

_____

☐ Single ☐Married ☐Divorced ☐Widowed ☐Separated

Home #: _____ Cell #: _____

Employer: _____

Employer Address: _____

How long there? _____ Occupation: _____

Work #: _____ 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: _____

Previous Dentist: _____

Last Dental Visit: _____

SPOUSE INFORMATION

His/Her Name: _____

Employer: _____

Work #: _____ Ext: ____ SS# _____

Birthdate: ___/___/___ DL #: _____

Primary Dental Insurance:

Insurance Co. Name: _____

Address: _____

Phone #: (____) _____-_____

Insured's Name: _____

Relationship to Patient: _____

Insured's Birthdate: ____/____/_____

Insured's ID #: _____ Group #: _____

Insured's Employer: _____

Insured'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: _____

Insured's Address: _____

PERSON RESPONSIBLE FOR ACCOUNT:

Name: _____

Phone: (____) _____ Work: _____

Billing Address: _____

Relationship to Patient: _____

SS#: _____ Birthdate: ____/____/_____

Eaglesoft Medical History-PRINT THIS

Patient Name: Birth Date: Date Created:

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
Have you ever been hospitalized or had a major operation?	○ 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	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	○ Yes ○ No	If yes
Have you ever received or had a reaction to botox or dermal fillers?	○ Yes ○ No	
Do you use tobacco?	○ Yes ○ No	

Women: Are you...

☐ Pregnant? ☐ Trying to get pregnant? ☐ Nursing? ☐ Taking Oral Contraceptives?

If pregnant/trying to get pregnant, please provide your current OB/GYN and phone number.	☐	If yes
If pregnant, how far along are you?	☐	If yes

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic
☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics
☐ Other

Other?	○ Yes ○ No	If yes
Do you use controlled substances?	○ Yes ○ No	If yes

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 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	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	Sleep Disorder	○ Yes ○ No				

Have you ever had any serious illness not listed ○ Yes ○ No If yes

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:

X Date:_____

BRIDGE DENTAL

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 setting? (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)

Are your teeth sensitive? (Y) (N)
(HOT) (COLD) (SWEETS) (PRESSURE)

Do your gums bleed during blushing or flossing?
(Y) (N)

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

What type of toothbrush do you currently use?
(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)

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

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

Do you currently use a nightguard? (Y) (N)

Do you need pre-medications prior to 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 to 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:** _____

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: _____

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