Dr. LJ Adam
LAWRENCE J. ADAM, DMD
Adam Associates Family Dental

Patient Registration Form

First name _____ **Middle initial**_____ **Last name**_____ **Gender** M or F

Preferred name_____ **DOB**_____ **Status:** Single Married Separated Divorced Widowed Child

Address _____ **City** _____ **State** _____ **Zip** _____

Home phone _____ **Cell phone** _____ **Texting capabilities?** Yes or No

Appointment reminders preference: *(please circle all that apply)* Home # Cell # E-mail All options

Social Security #_____ **E-mail**_____

Work phone_____ **Employer**_____ **Occupation**_____

Primary care provider_____ **Primary phone**_____

If college student: Full time Part time **Name of school**_____ **City**_____ **State**_____

Spouse/Parent name_____ **DOB**_____ **Cell phone**_____

Spouse/Parent Social Security #_____ **Spouse/Parent work phone**_____

Person to contact in case of emergency? _____**Phone**_____

How did you learn of our office? Family/Friend referral Search engine/online Social media Other

Dental Insurance Information

Insurance company_____ **Phone**_____

Name of insured_____ **Relationship to patient**_____ **DOB**_____

Group #_____ **Insured SS #**_____ **Insured ID #** *(If different from SS#)* _____

Employer_____ **Phone**_____ **Union or Local #**_____

Do you have any additional dental insurance? YES or NO ***If the answer is "yes," complete the following:***

Insurance company_____ **Phone**_____

Name of insured_____ **Relationship to patient**_____ **DOB**_____

Group #_____ **Insured SS#**_____ **Insured ID #** *(If different from SS#)* _____

Employer_____ **Phone** _____ **Union or Local #** _____

Last dental visit? _____ X-rays? _____Cleaning? _____

List additional family members covered by your insurance plan/account: _____

_____

Consent

I have read and understand the HIPAA information offered to me. I give permission to Adam Associates, P.C., to release my (or my child's) medical and/or financial information to _____ _____. *(spouse, immediate family member, partner, etc.)*

I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me or to my child during the period of such care to third party payers and/or other health practitioners. I authorize and request my insurance company to pay directly to the doctor's group insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or the behalf of my dependents.

Patient, parent, or guardian's signature _____

Date _____

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Smile Evaluation

1. Do you like the way your teeth look? Yes ( ) No ( )
Explain: _____

2. Are you happy with the color of your teeth? Yes ( ) No ( )
Explain: _____

3. Would you like for your teeth to be whiter? Yes ( ) No ( )
Explain: _____

4. Would you like your teeth to be straighter? Yes ( ) No ( )
Explain: _____

5. Do you have spaces between your teeth that you would like closed? Yes ( ) No ( )
If yes, Upper ____ Lower ____ Both ____ ?

6. Would you like your teeth to be longer? Yes ( ) No ( )
Explain: _____

7. Do you like the shape of your teeth? Yes ( ) No ( )
Explain: _____

8. Do you have missing teeth that you would like replaced? Yes ( ) No ( )
Explain: _____

9. Do you have old silver fillings that you would like to be replaced with tooth-colored fillings? Yes ( ) No ( )

10. If you could change anything about your smile, what would you change?

_____

_____

_____

Do you wish you had whiter, brighter teeth? We can help!

- Venus White pre-filled whitening trays — $60
- Custom home bleaching trays with three bleaching tubes — $288 each or $576 for both
  - Bleaching refill tubes for your home bleaching trays — $24

We run specials throughout the year. If interested in any of the above services, let us know.