

**Craig Q. Adams, DMD PA
William B. Cheek, DDS PA**

11001 Raven Ridge Rd., Suite 101 • Raleigh, NC 27614 • 919-866-1360

Patient ID # _____

PLEASE PRINT

1 PATIENT INFORMATION

Today's Date _____

Patient Name _____
Last Name

_____ First Name Middle Initial Preferred Name

Address _____

City _____

State _____ Zip _____

E-mail _____

Driver's License # _____ State _____

SS # _____

Sex M F Age _____ Birthdate _____

Married Widowed Single Minor

Separated Divorced

Patient Employer/School _____

Occupation _____

Employer/School Address _____

Who is responsible for this account? _____

Spouse, Parent or Guardian's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

2 DENTAL INSURANCE

Subscriber's Name _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? Yes No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Dr. Craig Q. Adams & Dr. William B. Cheek all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentists may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Signature of Patient, Parent, Guardian or Personal Representative

Please print name of Patient, Parent, Guardian or Personal Representative

Date Relationship to Patient

3 PHONE NUMBERS

Home (____) _____ Work (____) _____ Ext ____ Cell Phone (____) _____

Spouse's Work (____) _____ Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT:

Name _____ Relationship _____

Home Phone (____) _____ Work Phone (____) _____

4 DENTAL HISTORY

Reason for today's visit _____

Former Dentist _____

City/State _____

Date of last dental visit _____

Date of last dental X-rays _____

Place a mark on "yes" or "no" to indicate if you have had any of the following:

- Bad Breath Yes No
- Bleeding Gums Yes No
- Blisters on lips or mouth Yes No

- Burning sensation on tongue Yes No
- Chew on one side of mouth Yes No
- Dry mouth Yes No
- Fingernail biting Yes No
- Food collection between the teeth Yes No
- Foreign object impaction Yes No
- Gums swollen or tender Yes No
- Lip or cheek biting Yes No
- Loose teeth or broken fillings Yes No
- Mouth breathing Yes No
- Mouth pain, brushing Yes No
- Orthodontic treatment Yes No
- Sensitivity to cold Yes No

- Sensitivity to heat Yes No
- Sensitivity to sweets Yes No
- Sensitivity when biting Yes No
- Sores or growths in your mouth Yes No
- TMD Yes No
- Pain around ear Yes No
- Clicking or popping jaw Yes No
- Jaw pain or tiredness Yes No
- Grinding teeth Yes No

How often do you floss? _____

How often do you brush? _____

5 HEALTH HISTORY

Physician's Name & Phone # _____ Date of last visit _____

Have you ever taken any of the group of drugs referred to as "bisphosphonates" related to osteoporosis? These include Fosamax, Boniva, Actonel, Didronel, Reclast, Zometa, and Aclasta. Yes No For how long? _____

Place a mark on "yes" or "no" to indicate if you have had any of the following:

AIDS/HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No	Depression	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Radiation Treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis, Rheumatism	<input type="checkbox"/> Yes <input type="checkbox"/> No	Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Respiratory Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Heart Valves	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Date _____		Fainting or Dizziness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you use antibiotic premeds?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you use antibiotic premeds?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Scarlet Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Joints	<input type="checkbox"/> Yes <input type="checkbox"/> No	Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shortness of Breath	<input type="checkbox"/> Yes <input type="checkbox"/> No
Date _____		Heart Murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sinus Trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you use antibiotic premeds?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Skin Rash	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis Type _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	Special Diet	<input type="checkbox"/> Yes <input type="checkbox"/> No
Back Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding abnormally, with extractions or surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swollen Feet or Ankles	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaundice	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swollen Neck Glands	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaw Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemical Dependency	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tonsillitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemotherapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Circulatory Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Low Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tumor or growth on head or neck	<input type="checkbox"/> Yes <input type="checkbox"/> No
Congenital Heart Lesions	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mitral Valve Prolapse	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcer(s)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cortisone Treatments	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you use antibiotic premeds?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Venereal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cough, persistent or bloody	<input type="checkbox"/> Yes <input type="checkbox"/> No	Nervous/Anxiety Disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No	Weight Loss, unexplained	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you wear contact lenses?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No		
		Do you drink alcoholic beverages?	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____ drink(s) per day/wk	
		Do you smoke cigarettes, pipes or cigars?	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____ per day/wk	

Women:

Are you pregnant? Yes No Due Date _____ Are you nursing? Yes No Taking birth control pills? Yes No

MEDICATIONS

List any medications and supplements you are currently taking and the correlating diagnosis (if you have a list we may attach a copy):

Pharmacy Name _____

Phone (____) _____

ALLERGIES

<input type="checkbox"/> None	<input type="checkbox"/> Latex
<input type="checkbox"/> Aspirin	<input type="checkbox"/> Local Anesthetic
<input type="checkbox"/> Barbiturates (Sleeping pills)	<input type="checkbox"/> Penicillin
<input type="checkbox"/> Clindamycin	<input type="checkbox"/> Sulfa
<input type="checkbox"/> Codeine	<input type="checkbox"/> Other _____
<input type="checkbox"/> Iodine	_____

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CONSENT FOR TREATMENT

- I hereby authorize Dr. Adams / Dr. Cheek, and/or designated staff to take x-rays, study models, photographs and any other diagnostic aids deemed appropriate to make a thorough diagnosis for (full name of patient) _____'s dental needs.
- Upon such diagnosis, I authorize Dr. Adams / Dr. Cheek, and/or designated staff to perform all recommended treatment mutually agreed upon by me, including fluoride treatment, and to employ such assistance as required to provide proper care.
- I understand that this office files my insurance claims as a courtesy. Any claim not paid within 45 days of treatment is my responsibility.
- Lastly, I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service. A late charge of 1.5% (18 APR) for any balance over 60 days will be assessed to my account.

Signature _____ Date _____

If other than patient, indicate relationship: _____