Welcome to Allen Dentistry: In order for us to better serve you please provide the following information. All information provided will be kept confidential according to current HIPPA guidelines.

Patient Name_____ Parent/Guardian Name_____
Birthdate_____ Sex_____ Soc. Sec. #_____ Driver's License #_____
Home Address_____ City_____ State_____ Zip_____
Home phone_____ Cell Phone_____ Work Phone_____
E-Mail_____ Employer_____
Occupation_____ How Long There?_____
Spouse's Name (if applicable)_____ Soc. Sec.#_____
Spouse's Employer_____ Occupation_____ How Long There?_____
If Patient is a student: Name of School/College_____ Full or Part time?_____
How did you hear about our office? □ Internet Search □ A Friend (if yes, who?)_____ □ Local Magazine
□ Website □ Banner □ Mailer

Primary Insurance

Name of Insured_____ Birthdate_____ Relationship to Patient_____
Insurance Company_____ Insurance Address_____
Insurance Phone_____ Soc. Sec. #_____
Subscriber ID#_____ Effective Date of Insurance_____ Group,
Contract, Local or Union #_____

In Case of Emergency

Physician's name_____ City_____ Phone_____
Emergency Contact_____ Phone_____

Agreement to pay for treatment and authorization to automate co-payments

I hereby acknowledge full responsibility for the payment of services rendered in behalf of the named patient whether or not they are covered by insurance. I understand payment is expected at the time of service. I understand that in certain circumstances my credit report may be requested. I understand that check payments may be converted to automatic bank drafts. I agree that if payment is extended beyond 30 days from the date of service to pay a rebilling charge of 1.7% of the unpaid balance, with minimum rebilling charge of $5.00 per month. I agree to pay collections costs and/or attorney's fees if a delinquent balance is placed with an agency for collection. I authorize my insurance company to make payments directly to the dental office for the benefits otherwise payable to me. I authorize release of my records to third party payers, other healthcare professionals or operations, or other entities as deemed necessary by this office. I authorize use of this signature for all insurance submissions. I authorize this office to charge my credit card or bank account for any unpaid balances, including those after insurance payment. I have received a copy of this office's Notice of Privacy Practices. I understand that appointments missed or cancelled without 24 hours notice are subject to a $35 cancellation fee. I understand that a deposit may be required to reserve certain appointment types and/or times. I understand estimates of treatment cost are valid for 90 days. I have reviewed the information on this form, and it is accurate to the best of my knowledge.

Signature:_____ Date:_____

Medical History

Have you ever been hospitalized? Please explain._____

Are you under the care of a physician or planning to see one for any reason? Please explain. _____

List any medications you are currently taking._____

_____

_____

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 Smoke? How much/day? _____ Do you drink alcohol? Drinks/week?_____

Women:

Pregnant/Trying to Get Pregnant? □ Yes □ No Due Date_____

Taking oral contraceptives? □ Yes □ No Nursing? □ Yes □ No

Allergies: Are you allergic to any of the following:

□ Aspirin □ Penicillin □ Codeine □ Local Anesthetics □ Acrylic □ Metal □ Latex □ Sulfa Drugs □ Other_____

Do you have, or have you ever 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	Sinus Trouble	□ Yes	□ No
Asthma	□ Yes	□ No	Fainting Spells	□ Yes	□ No	Irregular Heartbeat	□ Yes	□ No	Spina Bifida	□ Yes	□ No
Blood Disease	□ Yes	□ No	Dizziness	□ Yes	□ No	Kidney Problems	□ Yes	□ No	Stomach/Intestinal Disease		
Blood Transfusion	□ Yes	□ No	Frequent Cough	□ Yes	□ No	Leukemia	□ Yes	□ No		□ Yes	□ No
Breathing Problem	□ Yes	□ No	Frequent Diarrhea	□ Yes	□ No	Liver Disease	□ Yes	□ No	Stroke	□ Yes	□ No
Bruise Easily	□ Yes	□ No	Frequent Headaches	□ Yes	□ No	Low Blood Pressure	□ Yes	□ No	Swelling of Limbs	□ Yes	□ No
Cancer	□ Yes	□ No	Genital Herpes	□ Yes	□ No	Lung Disease	□ Yes	□ No	Thyroid Disease	□ Yes	□ No
Chemotherapy	□ Yes	□ No	Glaucoma	□ Yes	□ No	Mitral Valve Prolapse	□ Yes	□ No	Tonsillitis	□ Yes	□ No
Chest Pains	□ Yes	□ No	Hay Fever	□ Yes	□ No	Osteoporosis	□ Yes	□ No	Tuberculosis	□ Yes	□ No
Cold Sores	□ Yes	□ No	Heart Attack/Failure	□ Yes	□ No	Pain in Jaw Joints	□ Yes	□ No	Tumors or Growths	□ Yes	□ No
Congenital Heart Disorder			Heart Murmur	□ Yes	□ No	Parathyroid Disease	□ Yes	□ No	Ulcers	□ Yes	□ No
	□ Yes	□ No	Heart Pacemaker	□ Yes	□ No	Psychiatric Care	□ Yes	□ No	Venereal Disease	□ Yes	□ No
Convulsions	□ Yes	□ No	Heart Trouble/Disease	□ Yes	□ No				Yellow Jaundice	□ Yes	□ No

Dental- Do you have or have you ever had, any of the following?

Teeth Sensitive to:			Dry Mouth	□ Yes	□ No	Loose Teeth	□ Yes	□ No	Don't Sleep Well	□ Yes	□ No
Cold	□ Yes	□ No	Unhappy with previous dental			Floss Breaks or Hurts	□ Yes	□ No	Embarrassed of Teeth	□ Yes	□ No
Heat	□ Yes	□ No	work	□ Yes	□ No	Clench or Grind Teeth	□ Yes	□ No	Gag Easily	□ Yes	□ No
Sweets	□ Yes	□ No	Gums Bleed	□ Yes	□ No	Clicking/Popping Jaw	□ Yes	□ No	Worried about Cost	□ Yes	□ No
Chewing	□ Yes	□ No	Growths or Sores	□ Yes	□ No	TMJ or TMD	□ Yes	□ No	Worried about Time	□ Yes	□ No
Food Catches	□ Yes	□ No	Bad taste in mouth	□ Yes	□ No	Snore	□ Yes	□ No	Play Sports	□ Yes	□ No

Would you like whiter teeth?_____ Is there anything that bothers you (even just a little) about the appearance of your teeth or smile?_____

On a scale of 1 – 10 how anxious are you about dental treatment? (1=relaxed, 10=scared)_____

What did you like most about your last dentist? _____

Why did you leave your last dentist?_____

Did your parents have difficulties with their teeth or dental treatment?_____

Is there anything we can do to make your visits more comfortable?_____

Consent for Treatment

To the best of my knowledge the questions on this form have been accurately answered. I will inform Allen Dentistry of any changes to these answers. I authorize Allen Dentistry and its associates to perform those procedures deemed necessary or advisable to maintain my dental health or the dental health of my child. I understand that dental treatment and anesthesia entails risks such as bleeding, infection, nerve damage, fracture of teeth or bone, injury to muscles, bruising, muscle soreness, swallowing or inhaling small objects, breakage of instruments, pain during and after treatment, abrasions and lacerations to gums, cheeks, or tongue. I do voluntarily assume all possible risks that may be associated with dental treatment in hopes of obtaining the desired results.

Signature:_____ Date:_____