PATIENT INFORMATION

Patients Name: Last_____First_____MI_____Sex M F Birthdate_____Age_____

Married_____Divorced_____Single_____Widowed_____

Soc. Sec.#_____IF CHILD PROVIDE PARENT/GUARDIAN NAME(S)_____

Street_____Apt#_____City_____State_____Zip_____

Mailing Address Street_____Apt#_____City_____State_____zip_____

Home Phone_____Cell Phone_____Work Phone_____

EMAIL:_____PREFERRED METHOD OF CONTACT_____

EMERGENCY INFORMATION

In case of emergency, please provide contact information for the nearest relative or designated contact person at the patient's address:

Name_____Relationship_____Phone#_____

EMPLOYEMENT INFORMATION

Are you employed Y N Employers Name/Company_____Occupation _____

Employers Address_____City_____State_____Zip_____

PRIMARY INSURANCE INFORMATION

Subscribers' Name_____Birthdate_____ Soc. Sec#_____

Insurance Company_____Phone_____

Insurance Co. Address_____City _____State_____Zip_____

Group/ Policy #_____ID#_____

Patients relationship to Subscriber_____

SECONDARY INSURANCE INFORMATION

Subscribers' Name_____Birthdate_____ Soc. Sec#_____

Insurance Company_____Phone_____

Insurance Co. Address_____City _____State_____Zip_____

Group/ Policy #_____ID#_____Patients relationship to Subscriber_____

NAME_____**HEALTH HISTORY & REGISTRATION** DATE_____

PRIMARY PHYSICIAN INFORMATION

PHYSICIAN _____ Telephone _____Last visit_____

MEDICAL HISTORY

YES NO

☐ ☐ Are you under a physician's care now? If yes, explain_____
☐ ☐ Any hospitalizations in the past 5 years? If yes, explain _____
☐ ☐ Any serious illnesses or injuries? If yes, explain _____
☐ ☐ Do you smoke or use any form of tobacco? If yes, how often? _____
☐ ☐ Is pre-medication required before dental visits due to heart condition or artificial joint?
☐ ☐ Are you taking any prescriptions or OTC medications? If yes, list details in the Medication Section
☐ ☐ Do you have any known allergies? If yes please list _____

DO YOU HAVE, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY)

☐ACID REFLUX	☐BULIMIA	☐HEARING PROBLEMS	☐PSYCHIATRIC
☐ADHD	☐CANCER/MALIGNANCY	☐HEART ATTACK	☐RADIATION/CHEMO
☐AIDS/HIV	☐CEREBAL PALSY	☐HEART DISEASE	☐RESPIRATORY
☐ANEMIA	☐CHEMICAL DEPENDENCY	☐HEART MURMUR	☐RHEUMATIC FEVER
☐ANOREXIA	☐CHICKEN POX	☐HEPATITIS	☐SINUS PROBLEMS
☐ANXIETY	☐CONVULSIONS	☐HIGH BLOOD PRESSURE	☐STROKE
☐ARTIFICIAL HEART VALVE	☐DEPRESSION	☐KIDNEY DISEASE	☐THYROID
☐ARTIFICIAL JOINTS	☐DIABETES	☐LIVER PROBLEMS	☐TUBERCULOSIS
☐ARTHRITIS	☐DIZZINESS/FAINTING	☐MITRAL VALVE PROLASP	☐ULCERS
☐ASTHMA	☐EPILEPSY/SEIZURES	☐MONOLUCLEOSIS	☐VENEREAL DISEASE
☐AUTISM/ASPERGERS	☐FREQUENT EAR INFECTIONS	☐MULTIPLE SCLEROSIS	☐PACEMAKER
☐BLEEDING DISORDER	☐FREQUENT HEADACHES		

MEDICATION INFORMATION

ARE YOU CURRENTLY TAKING ANY OF THE FOLLOWING?

☐ ANTIBIOTICS/SULFA DRUG	☐ DAILY ASPIRIN
☐ BLOOD THINNERS	☐ CORTISONE/STEROIDS
☐ INSULIN	☐ ORAL CONTRACEPTIVES
☐ OTHER DIABETIC MEDS	☐ THYROID MEDS
☐ ANTIHISTAMINES/ALLERG	☐ BLOOD PRESSURE MEDS
☐ CANCER/CHEMO MEDS	☐ HEART MEDICATIONS
☐ NITROGLYCERINE	☐ OSTEOPOROSIS MEDS
☐ RECREATIONAL DRUGS	☐ OTHER_____

HAVE YOU EVER HAD A REACTION TO:

☐ ANTIBIOTICS
☐ SULFA DRUGS
☐ ASPIRIN
☐ NITROUS OXIDE
☐ ANESTHETIC
☐ METAL SENSITIVITY
☐ BARBITURATES
☐ LATEX
☐ CODEINE
☐ LATEX

PLEASE LIST ANY MEDICATIONS YOU ARE TAKING

DRUG NAME	***DOSAGE***	***REASON PRESCRIBED***
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

ALLEN FAMILY DENTAL
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NAME_____ **HEALTH HISTORY & REGISTRATION** **DATE**_____

PREVIOUS DENTIST INFORMATION

Dentist: _____Telephone_____
Address:_____City_____State_____Zip_____
Date of last dental visit:_____
Reason for changing:_____

HOW DID YOU HEAR ABOUT US?_____

It is important that we know about your Medical and Dental History. These facts have a direct correlation to your Dental Health. This information is strictly confidential and will not be released to anyone unless required by law. Thank you for taking the time to completely fill out this questionnaire.

DENTAL HISTORY

YES NO

- ☐ ☐ Are you currently having any dental pain or discomfort? If yes, explain_____
- ☐ ☐ Are your teeth sensitive to hot, cold, sweets or pressure?
- ☐ ☐ Do you floss your teeth? If so, how often?_____
- ☐ ☐ Do you have missing teeth other than wisdom teeth or orthodontic extractions?
- ☐ ☐ Have your missing teeth been replaced?
- ☐ ☐ Do you wear a denture or partials?
- ☐ ☐ Do you have concerns about the appearance of your teeth? If yes, explain_____
- ☐ ☐ Have you had any injuries to your mouth/teeth or head? If yes, explain_____
- ☐ ☐ Do you have Headaches, earaches, or neck pains?
- ☐ ☐ Do you grind your teeth? If so, do you wear a night guard?
- ☐ ☐ Does it hurt to grind or chew?
- ☐ ☐ Do you have a foul odor, smell or taste in your mouth?
- ☐ ☐ Does your gums bleed or feel tender or irritated?
- ☐ ☐ Do you have concerns about gum disease or a history of gum disease?
- ☐ ☐ Do you want to become a regular, continuing care patient in our practice?
- ☐ ☐ Are you apprehensive or nervous about dental treatment?
- ☐ ☐ If the patient is a child, are there any mouth habits? (thumb sucking, mouth breathing, bottle, pacifier)
- ☐ ☐ Does the patient(child) receive assistance with brushing and flossing? If yes how often?_____

WHAT'S IMPORTANT TO YOU?

The most important concerns regarding my dental treatment are:_____

What factors are most important for your satisfaction with our office?_____

Any additional concerns/comments?_____

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Financial Agreement

At Allen Family Dental we pride ourselves on offering the best customer service available and will gladly submit your claims to any insurance company you prefer. Remaining payment of your portion and co-pay is due no later than the day the dental service is rendered except for extensive treatment.

Minors must be accompanied by a parent or legal guardian. If the parents are separated or divorced, the person accompanying the minor will be responsible for copayment at the time of service.

All treatment plan costs presented are ESTIMATES only; You will be responsible for the applicable financial differences. Please understand that your specific policy is an agreement between you and your insurance company and you are responsible for any financial differences. Should for any reason the insurance benefits result in less that the coverage anticipated, you are responsible for the total obligation.

Every effort is made to bill your insurance directly for reimbursement; however, if they do not pay within 60 days, you are still responsible for all remaining treatment fees. If you fail to notify ALLEN FAMILY DENTAL of any insurance change, you will be fully responsible for any amount not paid by your insurance company.

There will be a finance charge of 1.5% per month (18% APR) on any balance 60 days past due. If sent to collections, you are responsible for all related fees and court costs. Any check not cleared through the bank and returned to our office because of an insufficient balance will incur to the patient a $35.00 service fee.

There are many times our patients require urgent or emergency treatment and therefore require an appointment as soon as possible. When patients give the office advance notice of their need to cancel a scheduled appointment, this time can then in turn be allocated to these patients in urgent need of treatment. In this way the office can best serve the needs of ALL patients. With this in mind, a fee of **$1.00 per minute of allotted time for your appointment will be charged if you cancel your appointment without a 48 hour notice.** Also, unless an emergency occurs , we expect to run on time for appointments, and we appreciate the same courtesy from you.

Workers Compensation claims will be filed for you. Please understand your insurance will assign a dollar amount that will be paid towards the claim, which may or may not cover the entire fee. Any amount not covered by the insurance, will be your responsibility.

We will bill all balances that remain on your account, after all insurance and co-pay amounts are applied, to your primary credit card on-file with the office. Please inform office personnel if you prefer to have a specific card used for billing. You will receive statement notification prior to any charges being applied.

Payment Options: Cash, Check, Visa, Mastercard, Discover, CareCredit (not all co-pays qualify), and Lending Club (allows payments over time with little to no interest)

_____	_____	_____
Patient, Parent or Guardian Signature	Print Name	Date

PATIENT CONSENT FOR PAYMENT OF BENEFITS

To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status of if my medication changes, I shall inform Dr. Allen and staff at the next appointment without fail.

I hereby authorize payment directly to ALLEN FAMILY DENTAL of the dental benefits otherwise payable to me.

I hereby authorize Allen Family Dental to release any information concerning my health or dental care, advice, treatment or supplies provided. This information is to be used in administering dental claims and/or discussing treatment options with other dental professionals. I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance on my account for any professional services rendered.

By signing below, I acknowledge that I have read and understand the statements mentioned above.

Signature:_____ Date:_____

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HIPPA Notice of Privacy Practice Acknowledgement of Receipt

Allen Family Dental will use and disclose your personal health information to treat you, to receive payment for care we provide, and for other health care operations. Health care operations generally include those activities we perform to improve the quality of care. The financially responsible party, if it is not me, has the right to discuss my account balance. We have prepared a detailed **NOTICE OF PRIVACY PRACTICES** to help you better understand our policies regarding to protected health information. The terms of this notice may change with time, and we will post the current notice at our facility and have copies available for distribution.

I also give **Allen Family Dental** permission to speak to the following people (if any) regarding my health information:

_____ _____

_____ _____

I hereby acknowledge that I have read and received a copy of **Allen Family Dental's** HIPAA Notice of Privacy Practices.

Signed: _____ Date: _____

Print Name: _____ Telephone: _____

If not signed by the patient, please indicate relationship:

☐ Parent or guardian of minor patient
☐ Guardian or conservator of an incompetent patient
☐ Beneficiary of personal representative of deceased patient

Name of Patient: _____

FOR OFFICE USE ONLY:
Signed form received by: _____

Acknowledgement refused: _____
Reason for refusal: _____