

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 <input type="checkbox"/> Yes <input type="checkbox"/> No	Cortisone Medicine <input type="checkbox"/> Yes <input type="checkbox"/> No	Hemophilia <input type="checkbox"/> Yes <input type="checkbox"/> No	Radiation Treatments <input type="checkbox"/> Yes <input type="checkbox"/> No
Alzheimer's Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis A <input type="checkbox"/> Yes <input type="checkbox"/> No	Recent Weight Loss <input type="checkbox"/> Yes <input type="checkbox"/> No
Anaphylaxis <input type="checkbox"/> Yes <input type="checkbox"/> No	Drug Addiction <input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis B or C <input type="checkbox"/> Yes <input type="checkbox"/> No	Renal Dialysis <input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia <input type="checkbox"/> Yes <input type="checkbox"/> No	Easily Winded <input type="checkbox"/> Yes <input type="checkbox"/> No	Herpes <input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever <input type="checkbox"/> Yes <input type="checkbox"/> No
Angina <input type="checkbox"/> Yes <input type="checkbox"/> No	Emphysema <input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatism <input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis/Gout <input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy or Seizures <input type="checkbox"/> Yes <input type="checkbox"/> No	High Cholesterol <input type="checkbox"/> Yes <input type="checkbox"/> No	Scarlet Fever <input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Heart Valve <input type="checkbox"/> Yes <input type="checkbox"/> No	Excessive Bleeding <input type="checkbox"/> Yes <input type="checkbox"/> No	Hives or Rash <input type="checkbox"/> Yes <input type="checkbox"/> No	Shingles <input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Joint <input type="checkbox"/> Yes <input type="checkbox"/> No	Excessive Thirst <input type="checkbox"/> Yes <input type="checkbox"/> No	Hypoglycemia <input type="checkbox"/> Yes <input type="checkbox"/> No	Sinus Trouble <input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No	Fainting Spells <input type="checkbox"/> Yes <input type="checkbox"/> No	Irregular Heartbeat <input type="checkbox"/> Yes <input type="checkbox"/> No	Spina Bifida <input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	Dizziness <input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Problems <input type="checkbox"/> Yes <input type="checkbox"/> No	Stomach/Intestinal Disease <input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Transfusion <input type="checkbox"/> Yes <input type="checkbox"/> No	Frequent Cough <input type="checkbox"/> Yes <input type="checkbox"/> No	Leukemia <input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke <input type="checkbox"/> Yes <input type="checkbox"/> No
Breathing Problem <input type="checkbox"/> Yes <input type="checkbox"/> No	Frequent Diarrhea <input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	Swelling of Limbs <input type="checkbox"/> Yes <input type="checkbox"/> No
Bruise Easily <input type="checkbox"/> Yes <input type="checkbox"/> No	Frequent Headaches <input type="checkbox"/> Yes <input type="checkbox"/> No	Low Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Disease <input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No	Genital Herpes <input type="checkbox"/> Yes <input type="checkbox"/> No	Lung 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	Glaucoma <input type="checkbox"/> Yes <input type="checkbox"/> No	Mitral Valve Prolapse <input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis <input type="checkbox"/> Yes <input type="checkbox"/> No
Chest Pains <input type="checkbox"/> Yes <input type="checkbox"/> No	Hay Fever <input type="checkbox"/> Yes <input type="checkbox"/> No	Osteoporosis <input type="checkbox"/> Yes <input type="checkbox"/> No	Tumors or Growths <input type="checkbox"/> Yes <input type="checkbox"/> No
Cold Sores <input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Attack/Failure <input type="checkbox"/> Yes <input type="checkbox"/> No	Pain in Jaw Joints <input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcers <input type="checkbox"/> Yes <input type="checkbox"/> No
Congenital Heart Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Murmur <input type="checkbox"/> Yes <input type="checkbox"/> No	Parathyroid Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	Venereal Disease <input type="checkbox"/> Yes <input type="checkbox"/> No
Convulsions <input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Pacemaker <input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care <input type="checkbox"/> Yes <input type="checkbox"/> No	Yellow Jaundice <input type="checkbox"/> Yes <input type="checkbox"/> No
	Heart Trouble/Disease <input type="checkbox"/> Yes <input type="checkbox"/> No		

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

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