

# WELCOME TO ALLEN FAMILY DENTISTRY

## PATIENT INFORMATION

Patient Name \_\_\_\_\_ Male\_\_ Female\_\_ Married\_\_ Single\_\_ Child\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Social Security # \_\_\_\_\_ Email \_\_\_\_\_  
Employer \_\_\_\_\_ Position \_\_\_\_\_  
Spouse, Parent or Guardian Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Employer \_\_\_\_\_ Position \_\_\_\_\_

## MEDICAL HISTORY

1. Do you have or have you had any of the following & when:

### Cardiovascular Conditions

\_\_ Angina \_\_\_\_\_  
\_\_ Artificial Heart Valve \_\_\_\_\_  
\_\_ Heart Attack \_\_\_\_\_  
\_\_ Heart Murmur \_\_\_\_\_  
\_\_ High Blood Pressure \_\_\_\_\_  
\_\_ Mitral Valve Prolapse \_\_\_\_\_  
\_\_ Bypass Surgery \_\_\_\_\_  
\_\_ Pacemaker \_\_\_\_\_

### Respiratory Conditions

\_\_ Tuberculosis \_\_\_\_\_  
\_\_ Emphysema \_\_\_\_\_  
\_\_ Asthma Gastrointestinal Conditions \_\_\_\_\_  
\_\_ Gastrointestinal Reflux \_\_\_\_\_  
\_\_ Stomach Ulcers \_\_\_\_\_  
\_\_ Gallbladder Trouble/Stones \_\_\_\_\_  
\_\_ Liver Disease \_\_\_\_\_  
\_\_ Hepatitis A, B or C \_\_\_\_\_  
\_\_ Cirrhosis \_\_\_\_\_

### Endocrine Conditions

\_\_ Thyroid Problems \_\_\_\_\_  
\_\_ Diabetes (specify type) \_\_\_\_\_  
\_\_ Hypoglycemia \_\_\_\_\_

### Psychological Conditions

\_\_ Depression \_\_\_\_\_  
\_\_ Anxiety/Panic Disorders \_\_\_\_\_  
\_\_ Eating Disorder \_\_\_\_\_  
\_\_ Drug/Alcohol Dependency \_\_\_\_\_

### Genitourinary Conditions

\_\_ Kidney Problems \_\_\_\_\_  
\_\_ Dialysis \_\_\_\_\_

### Bone & Joint Conditions

\_\_ Osteoarthritis \_\_\_\_\_  
\_\_ Osteoporosis \_\_\_\_\_  
\_\_ Hip/Joint Replacement \_\_\_\_\_

### Bleeding Abnormalities

\_\_ Prolonged Bleeding \_\_\_\_\_  
\_\_ Anemia \_\_\_\_\_  
\_\_ Sickle Cell Disease \_\_\_\_\_  
\_\_ Epilepsy \_\_\_\_\_  
\_\_ Convulsions/Seizures \_\_\_\_\_  
\_\_ Stroke \_\_\_\_\_

### Cancer (specify site)

\_\_ Surgery \_\_\_\_\_  
\_\_ Chemotherapy \_\_\_\_\_  
\_\_ Radiation Therapy \_\_\_\_\_

### Immune Conditions

\_\_ AIDS or HIV Infection \_\_\_\_\_  
\_\_ Immunosuppression \_\_\_\_\_

### Other

\_\_ Glaucoma \_\_\_\_\_  
\_\_ Organ/Tissue Transplant \_\_\_\_\_  
\_\_ Rheumatic Fever \_\_\_\_\_  
\_\_ Latex Allergy \_\_\_\_\_  
\_\_ Currently Pregnant \_\_\_\_\_

2. Please list any drugs or medications you are currently taking \_\_\_\_\_

3. Are you sensitive or allergic to any drugs? \_\_\_\_\_

4. Have you ever taken Phen-Fen? When? \_\_\_\_\_

5. Have you ever been hospitalized? Why? When? \_\_\_\_\_

6. Do you use tobacco products? Which ones? \_\_\_\_\_

7. Are you under the care of a physician? \_\_\_\_\_ Name/City/State \_\_\_\_\_

**\*FOR OFFICE USE ONLY\*** Comments \_\_\_\_\_

Person to contact for emergency \_\_\_\_\_ Relationship \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

# DENTAL HISTORY

1. Reason for today's visit? \_\_\_\_\_

2. How long since your last visit to the dentist? \_\_\_\_\_

Previous Dentist \_\_\_\_\_ City/State \_\_\_\_\_

3. How often do you floss your teeth? \_\_\_\_\_

4. If you could change something about your smile, what would it be? \_\_\_\_\_

5. Do you have or have you had any of the following:

- Periodontal Disease
- Snore
- Popping or Clicking of the Jaw
- Use an Electric Toothbrush
- Grind or Clench Teeth
- Allergic Reaction to Metal Filling, Crown or Dental Appliance
- Gums Bleed When You Brush
- Sores, Blisters or swelling of Gums, Lips or Cheeks
- Orthodontic Treatment

## INSURANCE INFORMATION

Do you have Dental Insurance?  YES  NO

If yes, please fill out the following information and provide a copy of insurance card.

Name of Insured \_\_\_\_\_ Date of Birth \_\_\_\_\_

Social Security # \_\_\_\_\_ Employer \_\_\_\_\_

INSURANCE FILING - The patient is ultimately responsible for payment in full of their account, not the insurance company. We do, however, file dental insurance claims as a courtesy to our patients. We can only make estimates regarding your insurance benefits based on the information provided by you and the insurance company. In the event your insurance company does not pay as much as expected, the remaining balance is due and payable immediately by you, the patient.

ASSIGNMENT OF INSURANCE BENEFITS - I hereby assign directly to Allen Family Dentistry, dental insurance benefits otherwise payable to me. I hereby authorize the release of any information relating to any claims. I understand I am financially responsible for charges not paid by this assignment.

\*As a convenience to you, we are happy to file on your primary insurance plan. However, we are unable to file on your secondary plan, but can provide the information needed for you to file yourself.

## ACCOUNT INFORMATION

Person Responsible for Account \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

FINANCIAL AGREEMENT - Payment in full for all charges is required at time of visit, unless prior arrangements have been made. Advanced payments are allowed, but not refundable.

DELINQUENT ACCOUNTS - All delinquent accounts (30 days or older) are subject to reasonable service charges and/or legal interest rates.

COLLECTION PROCEEDINGS - in the event your account is turned over to a collection agency for non-payment or other delinquency, you will be responsible for payment of any collection costs and/or attorney fee, in addition to the balance owed. Any account turned over to a collection agency forfeits any past special fees and/or discounts. Such special fees and/or discounts will be reversed and you will be responsible for payment of regular fees for procedures at the time of service.

FAILED APPOINTMENTS - Failed appointments (less than 24 hours notice) are a significant contributor to rising health care costs. Individuals who fail to show for a confirmed appointment may be assessed a fee on the length of the missed appointment.

I hereby consent to treatment, including the use of any anesthetics, sedatives or x-rays, as may be deemed necessary by the doctor. I have completely read and understand the contents of this agreement and agree to comply with all policies. I attest to the accuracy of the information on this page.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Name of Person Signing for Patient \_\_\_\_\_ Relationship \_\_\_\_\_

Who may we thank for referring you to our office? \_\_\_\_\_