ALLEN DENTAL

Where Dentistry is an Art

PATIENT REGISTRATION FORM

PATIENT NAME _____
PREFERRED NAME _____
FAMILY MEMBERS SEEN BY US _____
ADDRESS _____
CITY _____ STATE _____ ZIP _____
HOME PHONE _____ WORK PHONE _____
CELL PHONE _____ EMAIL ADDRESS _____
PREFERRED METHOD OF CONTACT ☐ PHONE ☐ EMAIL ☐ TEXT
BIRTHDATE _____ GENDER ☐ M ☐ F
SOC. SEC. # _____ MARITAL STATUS _____
EMPLOYER _____
SPOUSE _____ EMPLOYER _____
EMERGENCY CONTACT PERSON _____ PHONE _____
REFERRED BY _____

INSURED OR RESPONSIBLE PARTY INFORMATION

NAME _____ RELATIONSHIP _____
ADDRESS _____ CITY, STATE, ZIP _____
SOC. SEC. # _____ PHONE # _____ BIRTHDATE _____

DENTAL INSURANCE CO. _____
ADDRESS _____ CITY, STATE, ZIP _____
PHONE # _____ GROUP # _____ ID # _____
SUBSCRIBER NAME _____ BIRTHDATE _____
SOC. SEC.# _____ EMPLOYER _____

(SECONDARY COVERAGE)
INSURANCE CO. _____
ADDRESS _____ CITY, STATE, ZIP _____
PHONE # _____ GROUP # _____ ID # _____
SUBSCRIBER NAME _____ BIRTHDATE _____
SOC. SEC.# _____ EMPLOYER _____

I understand and agree that regardless of insurance status, I am completely responsible for payment of my account for services rendered. I certify that the above information is true and correct. This signature on file is my authorization for the release of information necessary to process any of the insurance benefits. My signature authorizes that all insurance benefits are to be made payable directly to Allen Dental. This office reserves the right to verify the credit status of potential patients and/or parents of the patient prior to extending credit for the treatment. At the discretion of the office we may use the services of one or more credit reporting agencies.

SIGNATURE _____ DATE _____

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PATIENT HEALTH QUESTIONNAIRE

Although dental personnel primarily treat the area in and around the mouth, your mouth is a part of your entire body. Health conditions that you have, or medications that you take have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

What is your main dental need? _____

Are you under a physician's care now? Yes No If yes, please explain: _____

Have you ever been hospitalized or had a major operation? Yes No If yes, please explain: _____

Have you ever had a serious head or neck injury? Yes No If yes, please explain: _____

Are you taking any medications, pills, or drugs? Yes No If yes, please explain: _____

Do you take, or have you taken, Phen-Fen or Redux? Yes No If yes, please explain: _____

Have you ever taken Fosamax, Boniva, Actonel, Zometa or any other medications containing bisphosphonates? Yes No If yes, please explain: _____

Are you on a special diet? Yes No If yes, please explain: _____

Do you use tobacco? Yes No If yes, what form/how long: _____

Women: Are you Pregnant/Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No

Are you allergic or had a reaction to any of the following?

Dental Anesthetics Penicillin Codeine Sulfa Drugs Metal Aspirin Latex

Other: _____ If yes, please explain: _____

Do you use controlled substances? Yes No _____

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

Have you ever had any serious illness not listed above? Yes No If yes, please explain:_____

Comments:

_____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the dental office of any changes in medical status.

Print patient name _____Signature of patient or Guardian _____ Date_____

Doctor Signature_____ Date_____

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NOTICE TO PATIENT

Allen Dental is happy to have you as a patient and we are committed to serving your dental needs. Part of this service is to ensure that you are fully aware of your responsibilities. We are providing you with this information and hope that you will ask us if you have any questions regarding the following.

- **INSURANCE** – as a courtesy to our patients, we file all claims to your insurance company except those claims known not to be covered by insurance, i.e. cosmetic, bleaching, oral health products.
    - Filing the claim does not guarantee coverage or payment from your insurance company.
    - It is your responsibility to know your coverage and inform us of any treatments that may not be covered or that you do not want performed. If there is ever a question regarding coverage, please call your insurance carrier prior to treatment to clarify details of your policy.
    - Any portion not paid by insurance is the patient's responsibility.
    - Any claim not paid by your insurance company within 60 days is also the patient's responsibility. You may be required to call on your claim to expedite payment.
    - At your request, we will submit crown and bridge pre-authorizations to your insurance company to find out what the patient's estimated financial responsibility would be for those services. However, pre-authorization does not guarantee payment for those services.
- **RESPONSIBLE PARTY** – A person financially responsible for the account and all balances due must be identified. This person must make sure payments are made on this account.
- **RATES** – Our rates are usual customary for our area as set by the American Dental Association, and are subject to change. Rate changes are generally released every year in the fall.
- **PAYMENT IS DUE AT TIME OF SERVICE** including co-payments and any other estimated portion not paid by your insurance company. We have different payment options available upon request. If balance is not paid in full within 90 days after the date of service, 21% APR finance charge will start accruing on your account.
- **OTHER IMPORTANT INFORMATION:**
    - **Missed appointments** – We ask that our patients provide us with at least 24-hour notice or a failed appointment fee may be assessed. After multiple failed appointments a patient may be dismissed from practice.
    - **Agreement for Direct Payment** – By signing below, permission is granted to assign dental benefit payments to be paid directly to Allen Dental from my insurance company.
    - **Diagnostic Film Permission** – By signing below, permission is granted for Allen Dental to take any necessary diagnostic films, photos, or study models to properly enable complete diagnostic and accurate treatment. If you do not wish for films to be taken, please express this request to your assistant or hygienist immediately.
    - **Release of Information –** By signing below, permission is granted for Allen Dental to share any diagnostic information (treatment, X-rays, ect.) with your insurance company as needed for payment or with any other doctor needed for your treatment; in compliance with HIPAA.

I, acting as the responsible party (for self or my minor children), hereby agree to the terms and conditions above

_____ _____

Signature Date

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ACKNOWLEGEMENT OF RECEIPT OF PRIVACY PRACTICES

NOTICE TO PATIENT

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

_____

Please print your name here

_____

Signature

_____

Date

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- ☐ The patient refused to sign.
- ☐ Due to an emergency situation it was not possible to obtain an acknowledgement.
- ☐ We weren't able to communicate with the patient.
- ☐ Other *(Please provide specific details)*

_____

_____

_____

_____

_____

_____ _____

Employee signature Date