Dr. Allen

4025 W. Bell Rd., Suite 13
Phoenix, AZ 85053
602-978-0200

Welcome

Patient Information (Confidential)

Name _____ Birthdate _____ Soc. Sec. # _____

Address _____ City _____ State _____ Zip _____

Email _____ Home Phone _____ Cell Phone _____

Check Appropriate Box ❑ Minor ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

If Student, Name of School/College _____ City _____ State _____ ❑ Full-Time ❑ Part-Time

Patient or Parent/Guardian's Employer _____ Work Phone _____

Business Address _____ City _____ State _____ Zip _____

Spouse or Parent Guardian's Name _____ Employer _____ Work Phone _____

Whom May We Thank for Referring You? _____

Person to Contact in Case of Emergency _____ Phone _____

Responsible Party

Name of Person Responsible for the Account _____ Relationship to Patient _____

Address _____ Home Phone _____

Email _____ Cell Phone _____

Employer _____ Work Phone _____ SS# _____

Is this Person Currently a Patient of our Office: ❑ Yes ❑ No

We reserve the right to charge for appointments cancelled or broken without 24 hours advanced notice.
Payment is due in full at the time of treatment unless prior arrangements have been made.

Insurance Information

Name of Insured _____ Relationship to Patient _____

Address (If different from patient) _____ City _____ State _____ Zip _____

Birthdate _____ SS# _____ Date Employed _____

Name of Employer _____ Union or Local # _____ Work Phone _____

Address of Employer _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Policy/ID# _____

Ins. Co. Address _____ City _____ State _____ Zip _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ❑ YES ❑ NO IF YES, COMPLETE THE FOLLOWING

Name of Insured _____ Relationship to Patient _____

Address (If different from patient) _____ City _____ State _____ Zip _____

Birthdate _____ SS# _____ Date Employed _____

Name of Employer _____ Union or Local # _____ Work Phone _____

Address of Employer _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Policy/ID# _____

Ins. Co. Address _____ City _____ State _____ Zip _____

Please Complete Both Sides

Patient Medical History

Physician _____ Office Phone _____ Date of Last Exam _____

	Yes	No
1. Are you under medical treatment now?	❑	❑
2. Have you been hospitalized for any surgical operation or serious illness within the last 5 years	❑	❑
If yes, please explain _____		
3. Are you taking any medication(s) Including non-prescription medicine?	❑	❑
If yes, what medication(s) are you taking _____		
4. Have you ever taken Fen-Phen/Redux?	❑	❑
5. Do you use tobacco?	❑	❑
6. Do you use controlled substances?	❑	❑
7. Are you wearing contact lenses?	❑	❑
8. Are you currently taking Fosamax, Actonel, or Boniva?	❑	❑

9. Allergies	Yes	No
Local Anesthetics	❑	❑
Penicillin or any other Antibiotics	❑	❑
Sulfa Drugs	❑	❑
Barbiturates	❑	❑
Sedatives	❑	❑
Aspirin	❑	❑
Any Metals (e.g. nickel, mercury, etc.)	❑	❑
Latex Rubber	❑	❑
Other (please list) _____	❑	❑

10. Woman Only	Yes	No
a) Are you pregnant or think you may be pregnant?	❑	❑
b) Are you nursing?	❑	❑
c) are you taking oral contraceptive?	❑	❑

11. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?	Yes	No
	❑	❑

Conditions:	Yes	No	Conditions:	Yes	No	Conditions:	Yes	No
High Blood Pressure	❑	❑	Heart Disease	❑	❑	Chest Pains	❑	❑
Heart Attack	❑	❑	Cardiac Pacemaker	❑	❑	Easily Winded	❑	❑
Rheumatic Fever	❑	❑	Heart Murmur	❑	❑	Stroke	❑	❑
Swollen Ankles	❑	❑	Angina	❑	❑	Hay Fever / Allergies	❑	❑
Fainting / Seizures	❑	❑	Frequently Tired	❑	❑	Tuberculosis	❑	❑
Asthma	❑	❑	Anemia	❑	❑	Radiation Therapy	❑	❑
Low Blood Pressure	❑	❑	Emphysema	❑	❑	Glaucoma	❑	❑
Epilepsy / Convulsions	❑	❑	Cancer	❑	❑	Recent Weight Loss	❑	❑
Leukemia	❑	❑	Arthritis	❑	❑	Liver Disease	❑	❑
Diabetes	❑	❑	Joint Replacement or Implant	❑	❑	Heart Trouble	❑	❑
Kidney Diseases	❑	❑	Hepatitis / Jaundice	❑	❑	Respiratory Problems	❑	❑
AIDS or HIV Infection	❑	❑	Sexually Transmitted Disease	❑	❑	Mitral Valve Prolapse	❑	❑
Thyroid Problem	❑	❑	Stomach Troubles / Ulcers	❑	❑	Other _____	❑	❑

Patient Dental History

Name of Previous Dentist and Location _____ Date of Last Exam _____

	Yes	No
1. Do your gums bleed while brushing or flossing?	❑	❑
2. Are your teeth sensitive to hot or cold liquids / foods?	❑	❑
3. Are your teeth sensitive to sweet or sour liquids / foods?	❑	❑
4. Do you feel pain in any of your teeth?	❑	❑
5. Do you have any sores or lumps in or near your mouth?	❑	❑
6. Have you had any head, neck or jaw injuries?	❑	❑
7. Have you ever experienced any of the following problems in your jaw?	❑	❑
Clicking	❑	❑
Pain (joint, ear, side of face)	❑	❑
Difficulty in opening or closing	❑	❑
Difficulty in chewing	❑	❑
8. Do you have frequent headaches?	❑	❑
9. Do you clench your teeth?	❑	❑
10. Do you bite your lips or cheeks frequently?	❑	❑
11. Have you ever had any difficult extractions in the past?	❑	❑
12. Have you ever had any prolonged bleeding following extractions	❑	❑
13. Have you had any orthodontic treatment?	❑	❑
14. Do you wear dentures or partials	❑	❑
If yes, date of placement _____		
15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	❑	❑
16. Do you like your smile?	❑	❑

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and records of any treatment or examination rendered to me or my child to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for service. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

_____ _____

Signature of patient (or parent/guardian if minor) Date

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Daniel A. Allen, D.D.S., PC
4025 W. Bell Road, Suite 13
Phoenix, AZ 85053
(602) 978-0200

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Private Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name _____

Relationship to Patient: _____

Signature: _____

Date _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason:

Regarding Financial Agreement

Thank you for choosing our office as your dental care health provider. We are committed to your treatment being both a pleasant and successful experience. Please understand that payment for treatment and services rendered is considered part of your treatment. The following policy has proved instrumental in keeping dental care costs down for our patients by eliminating the costly administrative expenses associated with billing procedures.

We accept the following methods of payment:

Cash, Debit, Checks, Visa/MasterCard
Discover or American Express
Extended payment plan with:
CareCredit

If you are unable to keep a scheduled appointment, we ask that you please give us a 24 hour notice, otherwise you will be charged a broken appointment fee of $75.00.

Regarding Insurance

If you prefer, our office will file your insurance claim for you. This is a special service we provide for our patients to eliminate some of the often confusing paperwork associated with processing claim forms.

Please remember your insurance policy is a contract between you and your insurance company. Our office is not a party to that contract. If you prefer we await payment from your insurance company, we will require a credit card with authorization to transfer any balance left unpaid by your insurance company 30 days after the date of service.

Please be aware that some treatments provided may not be considered reasonable or necessary under your particular plan and labeled "non-covered" or "plan exclusion". Through the years our office has learned the level of coverage of any dental plan is directly related to the level of payment made to the plan by the policy holder's employer.

Thank you for your understanding our Financial Policy. Please let us know if you have questions or concerns.

I have read and agree to honor this Financial Policy.

X_____ Date_____

Signature of Patient or Responsible Party