PATIENT REGISTRATION AND MEDICAL HISTORY

(PLEASE PRINT IN BLACK INK ONLY)

Whom can we thank for referring you ( ) Insurance Co. ( ) Advertisement ( ) Our existing patient (provide name) _____

E-mail _____ Cell Phone _____

Work Phone _____ Home Phone _____

Patient _____
Last Name First Name Initial Sex Age Birth Date

Street Address _____ City _____ State ____ Zip _____

SS# _____ DL # _____ Expires on _____

Employed By_____ Occupation_____ Bus. Address _____

Name of Spouse _____ Occupation _____ Phone _____

In emergency, who should be notified? _____ Relationship _____ Phone _____

DENTAL INSURANCE INFORMATION

Subscriber _____ Relationship to Patient _____ Subscribers Date of Birth _____

Subscriber's SS# _____ Subscriber's DL # _____ Employer _____

Dental Insurance Co. _____ Telephone # for Dental INS Co._____ Group #_____

Secondary Dental Insurance Co. _____Telephone # for Secondary INS Co. _____ Group # _____

MEDICAL INSURANCE INFORMATION

Physician's Name _____ Physicians Phone #: _____ Date of Last Physical: _____

Subscriber _____ Relationship to Patient _____ Subscribers Date of Birth _____

Subscriber's SS# _____ Subscriber's DL # _____ Employer _____

Medical Insurance Co. _____ Telephone # for Medical INS Co._____ Group #_____

Secondary Medical Insurance Co. _____Telephone # for Medical INS Co. _____ Group # _____

MEDICAL HISTORY

Yes	No		Yes	No		Yes	No	
( )	( )	Heart Problems	( )	( )	Headaches	( )	( )	Rheumatic Fever
( )	( )	High Blood Pressure	( )	( )	Hepatitis, Jaundice, or Liver Disease	( )	( )	Sinus Problems
( )	( )	Low Blood Pressure	( )	( )	Cancer	( )	( )	AIDS or other
( )	( )	Circulatory Problems	( )	( )	Psychiatric Care	( )	( )	Immunosuppressive cond.
( )	( )	Nervous Problems	( )	( )	Chronic Diarrhea	( )	( )	Stroke
( )	( )	Radiation Treatment	( )	( )	Allergies to Anesthetics	( )	( )	Ulcer
( )	( )	Artificial Heart, Valves, or Joints	( )	( )	Allergies to Medicine or Drugs	( )	( )	Tuberculosis
( )	( )	Recent Weight Loss	( )	( )	General Allergies	( )	( )	Veneral Disease
( )	( )	Back Problems	( )	( )	Blood Disease	( )	( )	Chemical Dependency
( )	( )	Diabetes	( )	( )	Arthritis	( )	( )	Hemophilia
( )	( )	Respiratory Disease	( )	( )	Special Diet	( )	( )	Other _____
( )	( )	Epilepsy	( )	( )	Swollen Neck Glands			

Are you allergic or have you had any adverse reaction to any of the following medications:

Penicillin or other antibiotics	YES NO	Codeine or other narcotic medications	YES NO
Sulfa drugs or Iodine	YES NO	Valium, Sedatives, or sleeping pills	YES NO
Local anesthetics	YES NO	Bisphosphonate	YES NO
Aspirin or Ibuprofen	YES NO	Other _____	

Are you currently taking any of the following medications:

Antibiotics	YES NO	Anticoagulants (Blood thinners)	YES NO
Blood Pressure medication	YES NO	Steroids	YES NO
Osteoporosis medication	YES NO	Tranquilizers	YES NO
Aspirin, Ibuprofen or Naproxen	YES NO	Digitalis, Nitroglycerine or other heart medication	YES NO
Oral contraceptives	YES NO	Insulin or other blood sugar altering medication	YES NO

Have you ever taken or are you currently taking bisphosphonates, ie: Fosamax YES NO ______________________

List all medications that you take ______________________

Are you under the care of a physician? ______ If yes, for what conditions ______________________

If the patient is a child, what is his/her weight? ______________________

(WOMEN) Do you think you are/may be pregnant? ( )Yes ( )No. If yes, how many months ___________ Are you currently nursing _________

Are you allergic to Latex gloves? ( ) Yes ( ) No. Have you ever taken/ do you take Phen Phen , Redux? ( ) Yes ( ) No ______________

Is there anything else we should know about your medical history ______________________

The above information is accurate and complete to the best of my knowledge. It shall be used only for my treatment, billing, and processing of my insurance benefits. I will not hold my dentist or any member or his/her staff responsible for any errors or omissions that I may have made in the completion of this form. Any and all cost of rendered treatment not covered by my insurance shall be patient's responsibility.

Date: **Patient Signature:** **Dentist Signature:**

MEDICAL HISTORY UPDATE

Has there been any change in your health since your last dental appointment? ( ) Yes ( ) No
For what condition? ______________________ Are you taking any new medications ( ) Yes ( ) No List the new medications ______________________

Date _____________ Patient Signature ______________________ Dentist Signature ______________________

MEDICAL HISTORY UPDATE

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Date _____________ Patient Signature ______________________ Dentist Signature ______________________

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For what condition? ______________________ Are you taking any new medications ( ) Yes ( ) No List the new medications ______________________

Dental Questionnaire

Name _____ Date _____

Please answer the following questions so that we may treat you on a more individual basis, providing the care appropriate for your particular needs and desires.

1. Are you having any discomfort at this time? _____ Yes _____ No
   Any sensitivity to: _____ Cold _____ Hot _____ Sweets _____ Chewing

2. Is there any specific problem which brought you in today? _____ Yes _____ No
   If yes, please explain: _____

3. Date of last dental visit: _____

4. Name of previous dentist: _____ Phone number: _____

5. Reason for leaving your previous dental provider: _____

6. Does dental treatment make you nervous? _____ No _____ Slightly _____ Moderately
   _____ Extremely

7. Is there anything about receiving dental care that concerns you?
   _____

8. Do you have/do any of the following?
   Bad Breath _____ Yes _____ No Clicking Jaws _____ Yes _____ No
   Bleeding Gums _____ Yes _____ No Grind Teeth at Night _____ Yes _____ No

9. How often do you brush? _____
   Floss? _____Daily _____ Sometimes _____ Rarely

10. Sealants: Have you had special coating placed on your back teeth to protect your teeth from decay? _____ Yes _____ No

11. Are you interested in teeth whitening? _____ Yes _____ No
    If yes, _____Zoom _____ Take Home Kit

12. Are you interested in straitening your teeth with Invisalign? _____ Yes _____ No

13. Are you interested in changing your silver fillings to white? _____ Yes _____ No

14. What I really want from dental health is: _____

15. 10 years from now I would like my teeth to be: _____

16. I think my present state of dental health is: _____ Excellent _____ Good _____ Poor

17. Would you like more information about our payment plans? _____ Yes _____ No

18. Any additional comments? _____

Allure Family DENTAL
& SPECIALTY GROUP

Written Financial Policy

Thank you for choosing Allure Family Dental Group or Allure Dental Specialist of Huntington Beach. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:

You can choose from:

- Cash, Check, Visa, MasterCard, Debit Card or American Express
- Convenient Monthly Payment Options[i] from Care Credit
    - Allow you to pay over time
    - No Annual fees or pre-payment penalties

Please note:

Allure Family Dental Group and Allure Dental Specialist of Huntington Beach requires payment prior to the completion of your treatment. If you choose to discontinue care before treatment is complete, your refund will be determined upon review of your case.

For patients with dental insurance we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment on your behalf.[ii]

A fee of $50.00 is charged for patients who miss or cancel more than 1 time in a calendar year without 24 hour notice.

Allure Family Dental Group and Allure Dental Specialist of Huntington Beach charges 50.00 for returned checks.

If you have any questions please do not hesitate to ask. We are here to help you get the dentistry you want or need.

Patient, Parent or Guardian Signature Date

Patient Name (Please Print)

[i]Subject to credit approval

[ii]However, if we do not receive payment from your insurance carrier within 30 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.

Allure Family DENTAL
& SPECIALTY GROUP

Acknowledgement of Receipt

Of Notice of Privacy Practices

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

Print Name: _____

Signature _____

You may refuse to sign this Acknowledgement

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____