Welcome to Allen Heights Dental. Please fill out in entirety so that we can better assist you.

Patient's Name _________________________________ Social Security # ___________________

Address ______________________________ City ____________ State ________ Zip _________

Birthdate _________ M/F _______ Age _____ Married/Single/Divorced/Widowed ___________

Home Phone # ______________ Work Phone # ____________ Cell Phone # ________________

Email ________________________________ Work Email _________________________________

Is Patient a Student? _____________ If yes, school name ________________________________

Emergency Contact ______________ Relationship ______________ Phone # _______________

Person responsible for account _______________________ Relationship __________________

Social Security # ______________ Driver's License # _______________ Birth Date ___________

How did you find out about Allen Heights Dental?

- Advertising mailer/flyer
- Insurance company website
- Drove by and saw the office
- Friend/Family/Physician recommended (please specify) ___________________________
- Internet Advertisement
- Other (please specify) _____________________________

Are you having any discomfort at this time? ____

Have you been under the care of a medical doctor in the past 5 years? _________________________

If yes, for what? ____

Physician's Name ____________________________________ Phone # ________________________

Have you taken any medications or drugs in the past 2 years __________________________ Yes or No

Are you NOW taking any medications or drugs _____________________________________ Yes or No

If yes, please list all ____

____

Do you have any or had any disease, condition, or problem that has not been listed? ________ Yes or No

If yes, please list ____

ACKNOWLEDGEMENT:

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. I will notify the doctor of any change in my health or medication and understand at any time I may review these records and/or insert any amendments. I understand all information given is considered confidential.

Patient/Guardian Signature ____ Date ______________

Height ___________ Weight ___________ Gender ________ Do you smoke or use tobacco? Y/N _____

If female, answer the following:

Y	N	
☐	☐	Are you taking birth control pills?
☐	☐	Are you pregnant?
☐	☐	Are you nursing?

For Office use only:

BP	
Heart Rate	

Y	N	Conditions
☐	☐	Abnormal Bleeding
☐	☐	Alcohol abuse
☐	☐	Allergies
☐	☐	Anemia
☐	☐	Angina Pectoris
☐	☐	Arthritis
☐	☐	Artificial Bones
☐	☐	Artificial heart valve
☐	☐	Asthma
☐	☐	Blood Transfusion
☐	☐	Cancer – Chemotherapy
☐	☐	Colitis
☐	☐	Congenital Heart Defect
☐	☐	Cosmetic Surgery
☐	☐	Diabetes
☐	☐	Difficulty breathing
☐	☐	Drug abuse
☐	☐	Emphysema
☐	☐	Epilepsy
☐	☐	Fainting Spells
☐	☐	Fever Blisters
☐	☐	Frequent Headaches

Y	N	Conditions
☐	☐	Glaucoma
☐	☐	Hay fever
☐	☐	Heart Attack
☐	☐	Heart Surgery
☐	☐	Hemophilia
☐	☐	Hepatitis A
☐	☐	Hepatitis B
☐	☐	High Blood Pressure
☐	☐	HIV + AIDS
☐	☐	Kidney problems
☐	☐	Liver disease
☐	☐	Low blood pressure
☐	☐	Mitral valve prolapse
☐	☐	Pace maker
☐	☐	Pneumocystis
☐	☐	Psychiatric problems
☐	☐	Radiation therapy
☐	☐	Rheumatic fever
☐	☐	Seizures
☐	☐	Shingles
☐	☐	Sickle cell disease
☐	☐	Sinus problems

Y	N	Conditions
☐	☐	Stroke
☐	☐	Thyroid Problems
☐	☐	Tuberculosis
☐	☐	Ulcers
☐	☐	Venereal Disease
☐	☐	Yellow Jaundice

Y	N	Allergies
☐	☐	Aspirin
☐	☐	Codeine
☐	☐	Dental Anesthetics
☐	☐	Erythromycin
☐	☐	Jewelry
☐	☐	Latex
☐	☐	Metals
☐	☐	Penicillin
☐	☐	Tetracyline
☐	☐	Other

Dear Patients:

The Primary mission of Allen Heights Dental is to deliver the finest and most comprehensive health care available in a cost effective environment.

Payment for your services is acceptable with:

Cash/ Cashier's Check/ Money Order

Visa/ MasterCard/ Discover/ American Express/ Care Credit

PAYMENT IS DUE AT TIME OF TREATMENT INITIAL _______

Dental Insurance (Please fill out completely):

Subscriber Name: ______________________________ Relationship to Patient ___________ DOB ______

Address (if different than patient) ___________________________________ Soc. Sec. # ______________

Subscriber Employed By: _______________________________________ Business Phone: ____________

Insurance Company: ____ Phone Number: _____________

Insurance Company Address: ___________________________________ Subscriber ID: _______________

As a courtesy, we file your primary insurance, however any balance not paid by your insurance company within 45 days of services performed, will be the responsibility of the patient.
INITIAL _______

A 24 hour notice is required for all missed appointments. We reserve the right to charge a $25 fee for missed appointments, and a $50 fee for missed appointments for large treatments. INITIAL _______

I authorize my insurance company to pay the doctor, all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the doctor to release all information necessary to secure payment of benefits. I grant permission to use my records for publication in scientific and professional journals and presentations at any time during or after treatment with the understanding that my identity will remain confidential. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

Signature: ____ Date: _____________________________

ALLEN HEIGHTS DENTAL

ALLEN HEIGHTS DENTAL

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, ________________________________, acknowledge that I have received a notice of privacy practices for this office.

Signature: ____ Date: _________________________________

If a personal representative signs this form for the above named individual, complete the following:

Personal Representative's Name: ____

Relationship to Individual: ____

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

( ) Communication barriers prohibited obtaining the acknowledgement

( ) An emergency situation prevented us from obtaining acknowledgement

( ) Other (Please Specify)

____
____
____