ALLEN DENTAL GROUP
A FOUNDATION OF HEALTHY SMILES

Name:_____ Date of Birth:_____ Social Security Number:_____
Mailing Address:_____ Home Phone:_____ Cell Phone:_____
City:_____ State:_____ Zip Code:_____ Work Phone: _____
E-Mail:_____
How do you prefer to be contacted? _____

Dental Information

	Yes	No		Yes	No
Are you currently experiencing pain or discomfort?	☐	☐	Do you clench or grind your teeth?	☐	☐
Do your gums bleed when you brush or floss?	☐	☐	Do you feel nervous about dental treatment?	☐	☐
Are your teeth sensitive to cold, hot, sweets, or biting?	☐	☐	Have you had a bad experience in the past?	☐	☐
Do you have clicking, popping or discomfort in the jaw?	☐	☐	Have you had a serious head or mouth injury?	☐	☐

What is the reason for you visit today?

How do you feel about your smile?

What do you do at home to take care of your teeth?

Brushing: Electronic or Manual? How often? _____	☐	☐	Mouth rinse: How often? _____	☐	☐
Flossing: How often?	☐	☐	What type?		

Medical Information

	Yes	No	
Have you been under the medical care of a doctor in the past two years?	☐	☐	If yes, what for? _____
Have you been a patient in the hospital during the past two years?	☐	☐	If yes, what for? _____
Have you ever had any excessive bleeding requiring special treatment?	☐	☐	
Have you ever experienced an unusual reaction to dental anesthetic?	☐	☐	
Do you use tobacco?	☐	☐	If yes, what kind and how much?
Are you interested in quitting?			_____
Are you being treated for a heart condition?	☐	☐	If yes, please list the condition.
			_____
Do you have any artificial joints?	☐	☐	If yes, please list the date of surgery. _____
Please list **any** allergies. (i.e. Latex, Penicillin, metals, etc. _____			
Please list **any** medications, vitamins and supplements you take. _____			
WOMEN: Are you pregnant?	€	€	If yes, number of weeks?_____
Are you nursing?	€	€	Are you taking birth control pills or on hormone replacement? Yes € No €

Please circle any and all of the following that you have had in the past or currently have:

Acid reflux/chronic heartburn	Chemotherapy	Fainting or dizzy spells	Liver disease	Sinus trouble
Alcoholism	Chronic pain	Genital herpes	Osteoporosis	Stroke
Anemia	Cold sores	Glaucoma	Pain in joints	Thyroid disease
Arthritis	Cortisone medicine	Hay fever	Psychiatric treatment	Tuberculosis
Asthma	Diabetes Type I or II	Heart surgery	Rheumatism	Ulcers
Autoimmune disease	Drug addiction	Hemophilia	Rheumatic fever	Venereal disease
AIDS or HIV infection	Eating disorder	Hepatitis A B or C	Scarlet fever	X-ray or cobalt treatment
Blood transfusion	Emphysema	High blood pressure	Severe headaches or migraines	Yellow jaundice
Bruise easily	Epilepsy or seizures	Kidney failure	Sickle Cell disease	

Do you have any disease, condition, or problem not listed above?

To the best of my knowledge, all of the following preceding answers are true and correct. If I ever have any changes in my health, or medicines change, I will inform the staff at the next appointment without fail.

Signature of patient, Parent, or guardian: _____ Date: _____

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How did you find out about our office? (Circle)

Internet Insurance Company Advertisement

Friend/ Family Whom may we thank for your referral? _____

We offer a variety of ways to remind you of your appointments. Please circle the options that you would prefer:

Phone Call Text Message E-mail ALL

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our Notice provides a description of treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revision of our Notice, at any time by contacting us.

Right to Revoke: You will have the right to revoke this consent at any time by giving us written notice of your revocation. Please understand that revocation of this Consent will not effect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this consent.

Signature

I, _____, have had a full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this consent, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature_____ Date_____

If questions about billing, treatment, records or scheduling arise, my information can be shared with:

Name:_____ Relation:_____

Name:_____ Relation:_____

Signature_____ Date_____