Alldent Dental Center

Patient Registration

DATE_____

Patient Name _____ Age _____

Address _____ Home Phone _____ Cell _____

City _____ State _____ Zip _____ Email _____

Social Security # _____ Date of Birth _____

Sex: ____ M ____F ___ Single ___ Married ___ Divorced ___ Widowed ___ Separated

Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Best time to call _____

Who is responsible for this account? _____

Relationship to patient _____

Address _____ Phone _____

Responsible party employed by_____

Business Address _____ Business Phone _____

IN CASE OF EMERGENCY, WHO SHOULD BE NOTIFIED?

_____ Phone _____

Whom may we thank for referring you to this office? _____

AllDent Dental Center

Insurance Information

PRIMARY DENTAL INS. CARRIER SECONDARY DENTAL INS CARRIER

_____ _____

INSURED'S NAME _____

INSURED'S EMPLOYER _____

INSURED'S SS # _____

INSURED'S DATE OF BIRTH _____

Consent for Treatment

1. I hereby authorize doctor or designated staff to take x-rays , study models, photographs and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of Patient)_____'s needs.
2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
3. I agree to the use of anesthetics and other medication as a necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.
4. I agree to be responsible for payment of all services rendered on my behalf or my dependants. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand the credit card left on file will be charged within 3 days of agreed date and a late charge may be added to account.

Patient's signature_____ Date_____

Witness_____

Parent / Responsible Party's signature _____

Relationship to Patient _____

Alldent Dental Center

Health History

PHYSICIAN'S NAME _____

PHONE_____ADDRESS_____

DATE OF LAST PHYSICAL EXAMINATION _____

ARE YOU IN GOOD HEALTH? _____ YES _____ NO

ARE YOU UNDER THE CARE OF A PHYSICIAN? _____ YES _____ NO

IF SO, FOR WHAT? _____

ARE YOU TAKING ANY MEDICATION AT PRESENT? _____ YES _____ NO

LIST ALL MEDICINE TAKING _____

YOUR PHARMACY _____ PHARMACY PHONE _____

HAVE YOU EVER HAD ANY OF THE FOLLOWING? CHECK THOSE THAT APPLY. (ASK IF YOU HAVE A QUESTION, THIS IS VERY IMPORTANT!)

___ AIDS/HIV
___ ANEMIA
___ ARTHRITIS
___ ARTIFICIAL JOINTS
___ ASTHMA
___ BLOOD DISEASE
___ CANCER
___ COLD SORES/FEVER BLISTERS
___ CORTISONE MEDICATION
___ DIABETES
___ EMPHYSEMA
___ EPILEPSY/SEIZURES
___ EXCESSIVE BLEEDING
___ GLAUCOMA
___ HAY FEVER
___ HEAD INJURIES
___ HEART ATTACK
___ HEART DISEASE
___ HEART SURGERY
___ HEART MURMUR
___ HEPATITIS
___ HIGH BLOOD PRESSURE
___ JAUNDICE
___ KIDNEY DISEASE
___ LATEX SENSITIVITY
___ LIVER DISEASE
___ LOW BLOOD PRESSURE
___ MENTAL DISORDERS
___ MITRAL VALVE PROLAPSE
___ NERVOUS DISORDERS
___ PACEMAKER
___ RADIATION TREATMENT
___ RESPIRATORY PROBLEMS
___ RHEUMATIC FEVER
___ SINUS PROBLEMS
___ STOMACH PROBLEMS
___ STROKE
___ THYROID DISEASE
___ TUBERCULOSIS
___ TUMORS
___ ULCERS
___ VENERAL DISEASE

OTHER:_____

ARE YOU ALLERGIC TO ANY MEDICATIONS? YES _____ NO _____

PLEASE LIST ANY MEDICINES OR SUBSTANCES TO WHICH YOU ARE ALLERGIC

DO YOU USE TOBACCO PRODUCTS? _____

IS THERE ANYTHING ELSE WE SHOULD KNOW ABOUT YOUR MEDICAL HISTORY?

ARE YOU OR DO YOU SUSPECT THAT YOU ARE PREGNANT? ____ YES ____ NO

ARE YOU TAKING BIRTH CONTROL PILLS? ____ YES ____ NO

Alldent Dental Center

Dental History

WHAT IS THE REASON FOR YOUR VISIT TODAY? _____

DATE OF YOUR LAST DENTAL VISIT _____

WHAT WAS DONE AT THAT VISIT? _____

DATE OF LAST DENTAL CLEANING _____

DATE OF LAST DENTAL XRAYS _____

PREVIOUS DENTIST'S NAME _____PHONE _____

ADDRESS _____

HOW OFTEN DO YOU VISIT THE DENTIST? _____

HOW OFTEN DO YOU BRUSH YOUR TEETH? _____

WHAT DENTAL PROBLEMS DO YOU HAVE AT PRESENT? _____

ARE YOU HAPPY WITH YOUR SMILE? _____

IS THERE ANYTHING ABOUT YOUR SMILE THAT YOU WOULD CHANGE?

_____

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING:

____ TEETH SENSITIVE TO HOT
____ TEETH SENSITIVE TO SWEETS
____ LOOSE TEETH
____ FREQUENT HEADACHES
____ ORTHODONTIC TREATMENT
____ PERIODONTAL TREATMENT
____ INJURY TO HEAD, NECK, OR JAWS
____ GRIND TEETH
____ TEETH SENSITIVE TO COLD
____ BLEEDING OR SORE GUMS
____ BAD TASTE OR ODOR
____ FOOD PACKING BETWEEN TEETH
____ ORAL SURGERY
____ WEAR BITE APPLIANCE
____ SORE JAW JOINTS

ALL OF THE ABOVE INFORMATION IS TRUE. I WILL NOT HOLD THE DENTIST OR STAFF RESPONSIBLE FOR ANY ERRORS OR OMISSIONS IN THIS FORM.

Patient Signature_____

Date_____

Alldent Dental Center

Financial Policy

Thank you for choosing Alldent Dental Center as your health care provider. We are committed to your successful treatment. Please understand that a payment for your bill is a part of your treatment. The following is a statement of our Financial Policy which we require you read and sign prior to treatment.

- **FULL PAYMENT FOR ALL SERVICES PERFORMED IS REQUIRED. AS A COURTESY, WE WILL BILL YOUR INSURANCE COMPANY FOR YOU. YOU WILL BE HELD RESPONSIBLE FOR ANY AMOUNT THAT YOUR INSURANCE COMPANY DOES NOT PAY FOR ANY REASON.**
- **FULL PAYMENT OR CO-PAYMENT IS DUE AT TIME OF SERVICE.**
- **WE ACCEPT CASH, CHECK, AMEX, DISCOVER, AND MASTERCARD.**

Regarding Insurance:

We may accept assignment of benefits, with your co-payment on your first visit. We cannot bill your insurance company unless you give us your insurance information. Your insurance policy is a contract between you and your insurance. We are not party to that contract. Please be aware that some and perhaps all of the services provided may be non-covered service \s under your dental plan. Co-payments collected are estimates only.

ALL CO-PAYMENTS AND DEDUCTIBLES ARE DUE AT TIME OF SERVICE.

Usual and Customary Rates:

Alldent Dental Center is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any arbitrary determination of usual and customary rates by insurance companies.

Appointment Cancellation and Returned Checks:

We require at least a 24 hour notice in advance of any cancellation or a $40.00 charge will apply. Please help us to serve you better by keeping all appointments. Also, there will be a fee for Returned Checks of $20.00 per check.

I understand and agree to this financial policy:

X_____ Date _____