ALLURE DENTAL

Name:_____ **Birthdate**:_____/_____/_____

What would you like us to call you (e.g. Mr. Jones, Michael, Mike):_____

Address:_____ **City:**_____

State:_____ **Zip:**_____ **Email:**_____

Home Phone:_____ **Cell Phone:**_____

Emergency contact name:_____ **Phone:**_____

How did you hear about us/ Who can we thank for referring you? _____

What is your reason for making today's appointment? _____

Previous dentist /Office:_____ **Date of last dental visit:**_____

Do you have dental insurance? Yes ☐ No ☐ Policy Holder: ☐ Self ☐ Other
If the subscriber is someone other than yourself:
Subscriber name:_____ **Relationship to patient:**_____
Subscriber DOB: _____ **Subscriber Member ID:**_____
Group name:_____ **Group #:**_____
Subscriber SSN: _____

When it comes to dentistry, you:
☐ Love going to the dentist!
☐ Don't mind it.
☐ Dread it.
☐ Are EXTREMELY anxious. Sweaty palms just thinking about it.

Do your gums bleed while brushing or flossing?
☐ Yes ☐ No
Are your teeth sensitive to hot and/or cold?
☐ Yes ☐ No
Aware of clenching/grinding your teeth?
☐ Yes ☐ No

Do you have pain in any of your teeth?
☐ Yes ☐ No
Do you like your smile?
☐ Yes ☐ No
Have you had orthodontic treatment?
☐ Yes ☐ No

If you desire changes to the appearance of your smile, what are your chief concerns?

Physician's name: _____ **Town they practice in:**_____

Have you been hospitalized for a surgical operation or illness within the last five years?
☐ Yes:_____ ☐ No

Are you taking any medications? ☐ Yes (please fill out the names and amounts below, including over-the-counter)
☐ No

1. _____ 7. _____
2. _____ 8. _____
3. _____ 9. _____
4. _____ 10. _____
5. _____ 11. _____
6. _____ 12. _____

Do you use tobacco?
☐ Yes, currently.
☐ No. In the past, but not currently.
☐ No, Never.

Do you use controlled substances?
☐ Yes, currently.
☐ No, in the past, but not currently.
☐ No, Never.

Are you allergic to, or have you ever had an adverse reaction to the following:

Local anesthesia (e.g. Novocaine):	☐ Yes	☐ No
Antibiotics:	☐ Yes	☐ No, if yes, which ones?_____
Sulfa Drugs:	☐ Yes	☐ No
Metal (e.g. Nickel, Mercury, etc.):	☐ Yes	☐ No
Latex:	☐ Yes	☐ No We are proud to be a latex-free office.
Other (please list):	☐ Yes	☐ No _____

Are you currently taking any blood thinners (e.g. Aspirin, Coumadin, Warfarin)?	☐ Yes	☐ No
Are you currently, or have you ever taken intravenous medications for osteoporosis?	☐ Yes	☐ No
Have you been instructed to pre-medicate prior to dental appointments?	☐ Yes	☐ No
Do you have a persistent cough/throat clearing not associated with a cold?	☐ Yes	☐ No
Are you pregnant or think you may be pregnant?	☐ Yes	☐ No
Are you nursing?	☐ Yes	☐ No
Do you take oral contraceptives?	☐ Yes	☐ No

Do you have, or have you ever had any of the following?

High Blood Pressure:	☐ Yes	☐ No	Cancer:	☐ Yes	☐ No
Low Blood Pressure:	☐ Yes	☐ No	Radiation Therapy:	☐ Yes	☐ No
Heart Attack:	☐ Yes	☐ No	Anemia:	☐ Yes	☐ No
Cardiac Pacemaker:	☐ Yes	☐ No	Fainting/Seizures:	☐ Yes	☐ No
Heart Disease:	☐ Yes	☐ No	Rheumatic Fever:	☐ Yes	☐ No
Heart Murmur:	☐ Yes	☐ No	Tuberculosis:	☐ Yes	☐ No
Chest Pains:	☐ Yes	☐ No	Liver Disease:	☐ Yes	☐ No
Angina:	☐ Yes	☐ No	Hepatitis/Jaundice:	☐ Yes	☐ No
Mitral Valve Prolapse:	☐ Yes	☐ No	AIDS/HIV Infection:	☐ Yes	☐ No
Diabetes:	☐ Yes	☐ No	STD:_____	☐ Yes	☐ No
Respiratory Problems:	☐ Yes	☐ No	Thyroid Problem:	☐ Yes	☐ No
Asthma:	☐ Yes	☐ No	Stomach Trouble/Ulcer:	☐ Yes	☐ No
Hay Fever Allergies:	☐ Yes	☐ No	Acid Reflux:	☐ Yes	☐ No
Emphysema:	☐ Yes	☐ No	Do you use a CPAP:	☐ Yes	☐ No
Epilepsy/Convulsions:	☐ Yes	☐ No	Do you have trouble sleeping:	☐ Yes	☐ No
Stroke:	☐ Yes	☐ No	Are you frequently tired:	☐ Yes	☐ No
Joint Replacement:	☐ Yes	☐ No	Kidney Disease:	☐ Yes	☐ No
Recent Weight Loss:	☐ Yes	☐ No	Glaucoma:	☐ Yes	☐ No
Arthritis:	☐ Yes	☐ No	Other:_____	☐ Yes	☐ No

Sleep: Please circle your condition during the following activities:
0= Would never doze 1= Slight chance of dozing 2= Moderate chance of dozing
3= High chance of dozing

1. Sitting and reading 0 1 2 3
2. Watching television 0 1 2 3
3. Sitting inactively in a public place 0 1 2 3
4. Passenger in a car for over an hour 0 1 2 3
5. Lying Down to rest in the afternoon 0 1 2 3
6. Sitting and talking to someone 0 1 2 3
7. Driving a car, at a stop light or in traffic 0 1 2 3
8. Have you ever been told you snore? ☐ Yes ☐ No
9. Do you wake up tired or fatigued? ☐ Yes ☐ No
10. Do you have morning tension/migraine headaches? ☐ Yes ☐ No
11. Have you been diagnosed with chronic fatigue syndrome, Fibromyalgia, IBS, TMJ, ADD/ADHD?
    ☐ Yes _____ ☐ No

Is there anything else you would like us to know regarding your medical or dental history?

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 the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers 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 services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

_____ _____

Signature of Patient (Parent/Guardian if a minor) Date

HIPAA Privacy Policy Acknowledgement

Our Notice of Privacy Practices provides information about how we may use and release protected health information about you. You have the right to review our Notice before signing this form. As provided in our Notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy by writing our practice or requesting a copy from any of our staff.

You have the right to request that we restrict how protected health information about you is used or released for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we are bound to our agreement.

By signing this form, you consent to our use and release of protected health information about you for treatment, payment, or health care operations as described in our Notice. You have the right to revoke this consent, in writing, except where we have already made releases in reliance on your prior consent.

I, _____, have received a copy of Allure Dental's HIPAA policy.

"I acknowledge that I have received the full privacy notice."

_____ _____

Signature Date

_____ _____

Parent/ Guardian Date

Health information is shared only when necessary with other dental care providers, insurance carriers, or health care providers. I would like to allow the following individual(s) access my information regarding my appointments, payments, and treatments.

_____ _____

Name of individual Relationship

_____ _____

Name of individual Relationship

_____ _____

Name of Individual Relationship

OFFICE POLICY

Cancellation Policy
We are a patient-centered practice. When you schedule an appointment, we reserve time specifically for you with our doctor and assistant, or with the hygienist. We do not schedule more than one patient at a time with one provider---you have our undivided attention when you are here for an appointment! To keep our office running on-time, we ask that you arrive on time for your scheduled visit. We know that life happens and things come up. Please give us the courtesy of 2 business days' notice to reschedule an appointment. We retain the right to charge a fee to help cover the expense of a last minute cancellation or no-show appointment.

Financial Policy
Our goal is to work with you to maintain your oral health. We treatment plan to reach and/or maintain optimum health and comfort for your mouth. We work with you to find a way to complete the treatment you need without finances serving as a barrier.

If you have a dental insurance plan, we will assist you in understanding and maximizing your plan benefits. There are a lot of plans out there and they can be confusing! We'll work hard to help you sort out the details. Your copayments, when applicable, are due at the time of service. We will do our best to estimate your copayments ahead of time and collect your portion. If there is a discrepancy between our estimates and your copayment due after the insurance company has remitted their portion, we will send you a bill in the mail. You are financially responsible for any treatment completed in our office, but we work hard to be your ally in using your dental benefits. Ultimately your insurance plan is a contract between you, and the insurance company (or your employer and the insurance company).

If you don't have dental insurance, payment is due in full at the time of service. If you have treatments that take multiple visits, we will break the payments up according to the number of visit. For larger treatment plans, we will work with you to find a payment plan that is feasible. We also offer third party financing options…..just ask!

Health care is expensive, and we get that. We don't want you to avoid treatment and let things get worse due to finances. Talk to us and we'll do our best to find a way to make things work!

Acknowledgment of receipt of Office Policy:

_____ _____
Name (Printed) Date

_____
Signature

Dental Marketing Release

Authorization:
I authorize the use and disclosure of my name, photographic/video images, and/or testimonial for educational and/or marketing purposes by Allure Dental. I understand that information disclosed pursuant to this authorization may be subject to re-disclosure and may no longer be protected by HIPAA privacy regulations. I understand that I will not receive financial compensation.

Purpose:
My photographic/video images, and/or testimonial will be used for: Social Media and/or Advertising.

Revocability:
I understand that I may revoke this authorization at any time, but such revocation must be in writing addressed to the practice. Revocation affects disclosure moving forward and is not retroactive. This authorization expires 99 years from date signed.

Patient Name: _____ Date: _____

Patient Signature: _____