PATIENT REGISTRATION

PATIENT'S NAME:_____

RESPONSIBLE PARTY(if other than patient):_____

HOME PHONE:_____

WORK PHONE:_____ CELL PHONE:_____

MAILING ADDRESS:_____

CITY_____ STATE_____ZIP_____

E-MAIL ADDRESS:_____

SOCIAL SECURITY# _____DATE OF BIRTH:_____

GENDER:_____ MARITAL STATUS:_____

EMERGENCY CONTACT:_____PHONE _____

RELATIONSHIP 0F CONTACT TO YOU:_____

Can we send correspondence via e-mail?_____ Text Messaging?_____

DENTAL HISTORY

Name: _____

1) Who may we thank for referring you today? _____

2) What is the reason for your visit today? _____

3) When was your last dental visit? _____

4) When was your last dental cleaning? _____

5) When was your last Full Mouth X-Rays? _____

6) What is your previous dentist's name? _____ Phone # _____

7) How often do you have dental examinations? _____

8) How often do you brush your teeth? _____ Floss? _____

9) What other dental aids do you use (Water Pik, Interplak, Toothpick etc.)? _____

10) Do you have any dental/tooth problems now? _____ Describe _____

11) Are your teeth sensitive to hot/cold or sweets or chewing/biting? _____

12) Do you have Halitosis (Mouth Odors/Bad Breath)? _____

13) Do you have a bad taste in your mouth? _____

14) Do you get frequent cold (canker) sores or blisters? _____

15) Do your gums bleed when you brush or floss? _____

16) What brand/type toothpaste do you use? _____ Mouthwash _____

17) Have any of your family members experienced gum disease or tooth loss? _____

18) Have you noticed any loose teeth or change in your bite? _____

19) Does food tend to get caught between your teeth? _____

20) Do you clench or grind your teeth? _____ Do you bite your lips or cheeks _____

21) Do you hold foreign objects with your teeth (pencils)? _____ Do you bite your nails? _____

22) Are you a mouth breather when awake or asleep? _____

23) Have you experienced popping or clicking of the jaw? _____

24) Have you ever had pain in your jaws? _____

25) Have you ever had difficulty opening or closing your mouth?_____

26) Do you smoke?_____ How much?_____ Do you use snuff (chew tobacco)_____

27) Do you snore when sleeping?_____ Do you awake refreshed?_____

28) Has anyone reported that you choke or gasp for air while asleep?_____

29) Have you ever had Orthodontic (Braces) treatment?_____ Periodontal (Gum) treatment?_____

30) Have you ever had a serious injury to mouth or head?_____

31) Do you wear a partial denture/removable bridge?_____ If yes, when was it made?_____

32) Do you feel nervous about having dental treatment?_____

33) If so, what is your biggest concern?_____

34) Have you had an upsetting dental experience?_____ If so,describe?_____

35) When you look in the mirror, do you like the way your teeth look?_____

36) If no, what don't you like?_____

37) Do you think your teeth are white enough?_____ Are your teeth straight?_____

38) Are any of your teeth too big or too small?_____ Are you interested in Cosmetic Dentistry?_____

Signature _____ Date _____

TIME 12:58 PM Hugh G. Allen, D.D.S. DATE 2/22/2013

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: _____
Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____
Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____
Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No _____
Are you on a special diet? ◯ Yes ◯ No
Do you use tobacco? ◯ Yes ◯ No
Do you use controlled substances? ◯ Yes ◯ No

Women: Are you
Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs
☐ Other If yes, please explain: _____

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

AIDS/HIV Positive ◯ Yes ◯ No	Cortisone Medicine ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	High Cholesterol ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Breathing Problem ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Genital Herpes ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Osteoporosis ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Pacemaker ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Convulsions ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No
			Yellow Jaundice ◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No _____

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

ALLEN DENTAL, INC.
FINANCIAL POLICY

In an effort to keep fees reasonable, and to continue to provide quality care, we have established a payment policy. By executing this agreement you are agreeing to pay for all services that are received.

Payments: Our administrative team will work with you to handle your financial needs, however we do require all routine treatment paid in full at the time of service. If a financial contract is signed, payment is expected on the agreed due date, outlined in the contract. If a payment billing arrangement is made, the balance of your account is due and payable when the statement is issued, and is past due if not paid within 30 days.

Forms Of Payment: Cash, check, and credit cards are all acceptable forms of payment. We accept MasterCard, Visa, American Express, and Discover. In addition, we also offer third party financing, with processing taking only a few minutes. This is especially convenient if you will be having a comprehensive treatment plan.

Insurance: The financial coordinator will help you with your individual needs. If you have insurance benefits, we can provide an ESTIMATE of what your insurance company is expected to pay, but can make no guarantee of estimated coverage. All charges are your responsibility from the date the services are rendered.

Past Due Accounts: If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your debt to a collection agency, you agree to pay additional collection costs incurred from address searches, credit reports or attorney fees which can possibly equal 50% of the balance due. We may also take the claim to Small Claims Court. You agree to pay any court fees incurred in trying to collect the past due balance.

Returned Checks: There is a $30.00 fee for any checks returned by the bank. We prefer payment in cash on accounts with a history of a returned check.

Missed Appointment Fee: The second time a patient does not show up on time for an appointment, or cancels with less than 24 hours notice, we have the right to charge a $40.00 fee. Extenuating circumstances will be considered. This fee must be paid before a new appointment is scheduled. Patients with three missed appointments may be asked to transfer their records to another doctor.

Divorce: In case of divorce or separation, the party responsible for the account prior to the divorce or separation, remains responsible for the account. After a divorce or separation, the parent authorizing treatment (signing consent) for a child will be the parent responsible for subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

Effective Date: Once you have signed this agreement, you agree to all terms and conditions contained herein, and the agreement will be in full force and effect. This agreement applies to previous, current and future transactions.

I have read and understand the financial policy outlined above.

_____ _____

Patient's Name Responsible Party

_____ _____ _____

Relationship to Patient Signature Date

12379 PEMBROKE ROAD PEMBROKE PINES, FLORIDA 33025 954-885-7100

ALLEN DENTAL, INC.

INFORMATION FOR OUR PATIENTS WITH DENTAL INSURANCE

Your dental benefit program will assist you in obtaining and maintaining a superlative level of oral health.

IT IS IMPORTANT THAT YOU REALIZE, HOWEVER THAT

- Your dental benefit program is a contract between you, your employer, and the insurance company. **We are not a party to that contract.** The office files your insurance as a courtesy to you.
- Our office generally, but not necessarily, falls within the usual and customary fee structure, determined by your carrier.
- Dental insurance is not meant to be a "PAY-ALL", it is only meant to be an aid.
- The amount your plan pays is determined by the contribution you and your employer make to your dental plan. The smaller the contribution paid in to the plan for "insurance", the less you will receive. It is your responsibility to advise us of your insurance company coverage and restrictions.
- **Not all dental services are a covered benefit.** We make our recommendations based on your needs, not on what your insurance carrier may or may not cover.
- **You** *(not the insurance company)* are responsible to us for **all of our fees** for services rendered to you.
- For patients who have insurance, an **ESTIMATE** will be given of the benefits that the insurance company is expected to pay, and co-payment is expected at the time services are rendered.
- If you have any questions regarding your insurance, please contact your insurance carrier regarding the specifics of the plan.

  - I authorize the release of all necessary information
  - I authorize payment of benefits directly to the provider
  - I have read this form and agree to be financially responsible for all fees regardless of insurance coverage.

Signature: _____ Date: _____ _____

Please Print name: _____

12379 PEMBROKE ROAD
PEMBROKE PINES, FLORIDA 33025
(954) 885-7100 FAX (954) 885-0363

Adjunctive Oral Cancer Screening Acceptance Form

Complete each time the examination is performed and place in the patient's file

Our practice continually strives to provide important enhancements in oral health care for our patients. We are concerned about oral cancer and look for it in all at risk patients.

One person dies every hour from oral cancer in the United States.

Late detection of oral cancer is the primary reason that mortality rates are so dismal. As with most other cancers, age is the primary risk factor for oral cancer. Though tobacco use is a major predisposing risk factor, 25% of oral cancer victims have no lifestyle risk factors.

Oral Cancer Risk profile

Increased risk

- Patients age 40 and older (95% of all cases)
- 18-39 years of age combined with any of the following:
  - Tobacco use
  - Chronic alcohol consumption
  - Oral HPV infection

Highest risk

- Patients age 65 and older with lifestyle risk factors
- Patients with history of oral cancer

- 25% of oral cancers occur in people who don't smoke and have no other risk factors.

We find that using ViziLite Plus along with a visual oral cancer examination improves our ability to identify suspicious areas that may have been missed during the conventional examination. Early detection of precancerous tissue can minimize or eliminate the potentially disfiguring effects of oral cancer and possibly save your life. ViziLite Plus is a painless exam that gives us a better chance to find any oral abnormalities you may have at an early stage.

Dental insurance might not cover the ViziLite Plus exam. However, this office is happy to verify your coverage for you and will also provide you with a medical insurance form for you to use to file this procedure with your medical insurance. The fee for this enhanced examination is $15.

Yes. I authorize the clinician to perform the ViziLite Plus exam along with the standard oral cancer examination. I accept financial responsibility for this enhanced examination.

Print name: _____.

Signature: _____ Date: _____

No. I would prefer not to have the ViziLite Plus exam at this time.

Print name: _____.

Signature: _____ Date: _____

ALLEN DENTAL, INC.

HUGH G. ALLEN, D.D.S.

Patient Acknowledgement of Receipt of the Notice of Privacy Practices
And
Consent to Use and Disclose Information

I acknowledge that I was provided with a copy of the Allen Dental, Inc. Notice of Privacy Practices, describing how my health information may be used or disclosed under the federal law. Provided that Allen Dental, Inc. continues to its good faith effort to comply with the requirements of the federal privacy law, I hereby consent to the use and disclosure of my health information for the purpose s and the activities permitted under the federal privacy law.

I understand that I should read the Notice of Privacy Practices carefully. I am aware that the Notice may be changed at any time. I may obtain a revised copy by calling the office of Allen Dental, Inc. at (954) 885-7100.

I acknowledge that I have received a copy of Allen Dental's Notice of Privacy practices.

_____ _____
Patient Name (Please Print) Date

_____
Signature of Patient

_____
Patient Legal Representative (if applicable)

_____ _____
Signature of Legal Representative Date

FOR DENTAL OFFICE USE ONLY

_____
Office Staff Member Obtaining Signature

Reason signature and date were not obtained:

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us form obtaining acknowledgement
- Other (please specify) _____