NEW PATIENT INFORMATION

FULL NAME_____ TODAY'S DATE_____
NAME YOU PREFER TO BE CALLED_____ DATE OF BIRTH_____
STREET ADDRESS_____MAILING ADDRESS*_____
CITY_____ STATE_____ ZIP CODE_____ H #_____ C #_____
IF MARRIED, SPOUSE'S NAME_____ IF MINOR, PARENT'S NAME_____
E-MAIL ADDRESS_____ (H / W) *IF SAME, LEAVE BLANK

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WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?_____
HAS DR. ALLEN TREATED ANY OTHER FAMILY MEMBERS? NAME(S) _____
PERSON TO NOTIFY IN CASE OF AN EMERGENCY_____ PHONE _____
SPECIAL CIRCUMSTANCES/CONCERNS_____

PLACE OF EMPLOYMENT/ADDRESS_____ PHONE _____
PRESENT POSITION _____HOW LONG EMPLOYED HERE _____
SPOUSE EMPLOYMENT/ADDRESS _____ PHONE _____
PRESENT POSITION_____ HOW LONG EMPLOYED HERE _____

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PAYMENT FOR EACH VISIT (OR YOUR COST SHARE) IS EXPECTED AT THE TIME OF SERVICE UNLESS YOU HAVE MADE PRIOR FINANCIAL ARRANGEMENTS WITH OUR OFFICE. PAYMENT OPTIONS INCLUDE CASH, CHECK, VISA, MASTERCARD, DISCOVER AND INTEREST FREE FINANCING THROUGH WELLS FARGO.

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IF YOU HAVE INSURANCE THAT MAY PAY A PORTION OF YOUR TREATMENT, PLEASE COMPLETE THE FOLLOWING INFORMATION IN FULL:

NAME AND ADDRESS OF EMPLOYER_____
NAME AND ADDRESS OF INSURANCE COMPANY _____
MEDICAL ___ DENTAL ____ GROUP/POLICY # _____ NAME OF POLICY HOLDER _____
POLICY HOLDER'S SS #_____ OR ID # _____
PATIENT SOCIAL SECURITY # _____POLICY HOLDER'S BIRTHDATE _____

IF YOU HAVE COVERAGE UNDER A SECOND INSURANCE COMPANY, PLEASE COMPLETE THE FOLLOWING INFORMATION IN FULL:

NAME AND ADDRESS OF EMPLOYER_____
NAME AND ADDRESS OF INSURANCE COMPANY _____
MEDICAL ___ DENTAL ____ GROUP/POLICY # _____NAME OF POLICY HOLDER _____
POLICY HOLDER'S SS #_____ OR ID # _____
PATIENT SOCIAL SECURITY # _____POLICY HOLDER'S BIRTHDATE _____

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IN ORDER TO MAKE YOU AS COMFORTABLE AS POSSIBLE DURING ANY TREATMENT YOU REQUIRE, WE OFFER A WIDE RANGE OF RELAXANTS AND PAIN MEDICATIONS, INCLUDING INHALATION OF NITROUS OXIDE AND INTRAMUSCULAR DEMEROL. **ALL MEDICATIONS ARE INCLUDED IN THE COST OF TREATMENT, EXCEPT FOR NITROUS OXIDE AND DEMEROL, FOR WHICH THERE IS AN ADDITIONAL FEE.**

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I ATTEST THAT THE INFORMATION I HAVE PROVIDED ON BOTH SIDES OF THIS FORM IS ACCURATE TO THE BEST OF MY KNOWLEDGE.

(PATIENT'S SIGNATURE) _____(DATE) _____

(DOCTOR'S SIGNATURE)_____(DATE)_____

TO ASSIST DR. ALLEN IN YOUR DIAGNOSIS AND TREATMENT, PLEASE COMPLETE THE MEDICAL AND DENTAL INFORMATION OF THE REVERSE SIDE OF THIS FORM. WE APPRECIATE YOUR PATIENCE IN COMPLETING THIS INFORMATION.

PATIENT MEDICAL HISTORY

PHYSICIAN'S NAME _____ PHONE _____

DATE OF LAST VISIT _____ REASON FOR VISIT _____

ARE YOU RECEIVING MEDICAL TREATMENT NOW? NO YES IF YES, REASON _____

ARE YOU TAKING ANY MEDICATIONS REGULARLY? NO YES IF YES, WHICH ONES _____

_____

_____

DO YOU REQUIRE **PREMEDICATION** (ANTIBIOTICS) FOR ANY REASON? _____

DO YOU NOW, OR HAVE YOU HAD ANY OF THE FOLLOWING? IF YES TO ANY QUESTION, PLEASE EXPLAIN ON THE LINES BELOW.

ANEMIA	NO YES	OSTEOPOROSIS	NO YES	LUNG PROBLEMS	NO YES
ARTHRITIS	NO YES	GASTRIC ULER	NO YES	RHEUMATIC FEVER	NO YES
BLADDER PROBLEMS	NO YES	EXCESSIVE THIRST	NO YES	HEART CONDITION	NO YES
KIDNEY PROBLEMS	NO YES	GLANDULAR PROBLEMS	NO YES	THYROID PROBLEMS	NO YES
BLEEDING PROBLEMS	NO YES	HIGH BLOOD PRESSURE	NO YES	PSYCHIATRIC TREATMENT	NO YES
CLOTTING PROBLEMS	NO YES	LOW BLOOD PRESSURE	NO YES	VENEREAL DISEASE	NO YES
DIABETES	NO YES	HEPATITIS	NO YES	AIDS	NO YES
FAMILY DIABETES	NO YES	LIVER PROBLEMS	NO YES	SUBSTANCE ABUSE	NO YES
ARTIFICIAL JOINTS	NO YES	RECENT SURGERY	NO YES	PACEMAKER/STENTS	NO YES

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_____

HAVE YOU EVER TAKEN CORTISONE? NO YES WHEN, HOW LONG? _____

HAVE YOU EVER TAKEN ANTICOAGULANTS? NO YES WHEN, HOW LONG? _____

DO YOU TAKE ASPIRIN DAILY? NO YES DOSAGE _____

HAVE YOU TAKEN A BISPHOSPHANATE DRUG? NO YES HOW LONG? _____

DO YOU TIRE EASILY? NO YES WHEN _____

DO YOU BRUISE EASILY? NO YES DOES THE BRUISE LINGER? _____

DO YOU CONSIDER YOUR HEALTH GOOD? NO YES IF NO, EXPLAIN _____

DO YOU TAKE DAILY VITAMINS? NO YES FEMALES: MENOPAUSE? NO YES

FEMALES: PREGNANT? NO YES HOW MANY MONTHS PREGNANT _____

ARE YOU NOW OR HAVE YOU EVER BEEN **ALLERGIC** TO ANY OF THE FOLLOWING MEDICATIONS:

ASPIRIN	NO YES	DEMEROL	NO YES
ANTIHISTAMINES	NO YES	NOVOCAINE	NO YES
BARBITURATES	NO YES	PENICILLIN	NO YES
CODEINE	NO YES	ANTIBIOTICS	NO YES
LATEX	NO YES	WHICH ANTIBIOTICS?	_____

PLEASE LIST OTHER ALLERGIES:

_____

_____

_____

PATIENT DENTAL HISTORY

DENTIST _____ PHONE _____

DATE OF LAST DENTAL CLEANING _____

HOW OFTEN DO YOU BRUSH YOUR TEETH _____

DO YOUR JAW JOINTS CLICK OR POP?	NO YES	DO YOU GRIND YOUR TEETH AT NIGHT?	NO YES
DO YOUR GUMS BLEED WHEN YOU FLOSS/BRUSH?	NO YES	DO YOU CLENCH YOUR TEETH DURING THE DAY?	NO YES
DO YOU HAVE BAD BREATH OR BAD TASTE?	NO YES	DO YOU HAVE PAIN IN YOUR JAW JOINTS?	NO YES
HAVE YOU HAD PREVIOUS PERIODONTAL TREATMENT?	NO YES	DO YOU HAVE HEADACHES REGULARLY?	NO YES
DID ANYONE IN YOUR FAMILY LOSE ALL THEIR TEETH?	NO YES	DO YOU HAVE ANY LOOSE TEETH?	NO YES
DO YOU LIKE THE APPEARANCE OF YOUR TEETH?	NO YES	HAVE YOU HAD ORTHODONTIC TREATME NT?	NO YES
WOULD IT DISTURB YOU TO WEAR FALSE TEETH?	NO YES	DO YOU OFTEN HAVE FEVER BLISTERS?	NO YES
		DO YOU SMOKE?	NO YES
		IF YOU SMOKE, HOW MUCH?	_____

PERSONAL PRIORITIES

OUR GOAL IS TO PROVIDE YOU WITH THE BEST POSSIBLE CARE. PLEASE CIRCLE THE FIVE FACTORS WHICH ARE THE MOST IMPORTANT TO YOU IN OUR TREATMENT OF YOUR CASE. THIS QUESTION IS OPTIONAL. IF YOU DO NOT WISH TO ANSWER, LEAVE IT BLANK.

1. BEING ON TIME	2. FRIENDLINESS AND CONCERN	3. FEELING SAFE - PAINLESS
4. EXPLANATION OF TREATMENT	5. TREATMENT RESULTS	6. BEING LIKED BY STAFF
7. PERSONAL ATTENTION	8. NO CRITICISM BY STAFF	9. NOT LOSING CONTROL
10. PATIENT TESTIMONIALS	11. FAIR PRICE - VALUE	12. QUALITY TREATMENT