

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 _____ HOME PHONE _____
IF MARRIED, SPOUSE'S NAME _____ IF MINOR, PARENT'S NAME _____
E-MAIL ADDRESS _____ (H / W) _____ *IF SAME, LEAVE BLANK

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 _____

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.

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 SOCIAL SECURITY # _____ POLICY HOLDER'S BIRTHDATE _____
PATIENT SOCIAL SECURITY # _____ (REQUIRED BY INSURANCE COMPANY)

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 SOCIAL SECURITY # _____ POLICY HOLDER'S BIRTHDATE _____
PATIENT SOCIAL SECURITY # _____ (REQUIRED BY INSURANCE COMPANY)

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.

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

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 GAINED/LOST >10 LB RECENTLY? NO YES HOW MUCH _____
 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	PLEASE LIST OTHER ALLERGIES: _____ _____ _____
ANTIHISTAMINES	NO YES	NOVOCAINE	NO YES	
BARBITURATES	NO YES	PENICILLIN	NO YES	
CODEINE	NO YES	ANTIBIOTICS	NO YES	
LATEX	NO YES	WHICH ANTIBIOTICS?	_____	

PATIENT DENTAL HISTORY

DENTIST _____ PHONE _____

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

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| 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 |