ALLRED DENTISTRY

Thank you for selecting our dental health care team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us -- we will be happy to help.

Patient Information (CONFIDENTIAL) **ID/SS#** _____

Name _____ Birthdate _____/_____/_____

Address _____ City _____ State _____ Zip Code _____

Home (_____) _____ Cell(_____) _____ Email _____

Single _____ Married _____ Spouse or Parent/Guardian's Name _____

Person to Contact in Case of Emergency _____ Phone (_____) _____

Physician Name _____ Phone # _____ Last Physical _____/____/_____

Insurance Information

Name of Insured _____ Relationship to Patient _____

Birthdate ___/___/_____ ID/SS# _____ Policy ID# _____

Employer _____ Ins Comp _____

Responsible Party

Name of Person Responsible for this Account _____ DOB___/___/_____

Relationship to Patient _____ ID/SS# _____

Address _____ City _____ State _____ Zip _____

Home (_____) _____ Work (_____) _____ Employer (_____) _____

I understand this is a courtesy, Allred Family Dentistry files for insurance payment. I hereby authorize payment of the insurance benefits (otherwise payable to me) directly to this office. I also understand that I am responsible for payment of services rendered and also responsible for paying any co-payment, balance, and/or deductibles that my insurance does not cover.

Signature _____ Date _____/_____/_____

Patient Name: _____ **Date of Birth:** _____

Are you under physician's care now? ○ YES ○ NO **If yes,** _____

Have you ever been hospitalized/had major operation? ○ YES ○ NO **If yes,** _____

Have you ever had a serious head/neck injury? ○ YES ○ NO **If yes,** _____

Are you taking any medications, pills, or drugs? (We need a list of **ALL** medications before we can get you back)

○ YES ○ NO **If yes**, _____

Do you take, or have you taken, Phen-Fen or Redux? ○ YES ○ NO **If yes,** _____

Have you ever taken Fosamax, Boniva, Actonel or any other medication containing bisphosphonates? ○ YES ○ NO **If yes,** _____

Are you on a special diet? ○ YES ○ NO

Do you use tobacco? ○ YES ○ NO

Do you use controlled substances? ○ YES ○ NO If yes, _____

Women: **Are you:** ○ Pregnant ○ Nursing ○ Taking oral contraceptives

Are you allergic to any of the following?

○ Aspirin ○ Penicillin ○ Codeine ○ Acrylic ○ Metal ○ Latex
○ Sulfa Drugs ○ Local Anesthetics ○ Other: _____

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

○ AIDS/HIV	○ Cortisone Medicine	○ Hemophilia	○ Radiation Treatments
○ Alzheimer's Disease	○ Diabetes	○ Hepatitis A	○ Recent Weight Loss
○ Anaphylaxis	○ Drug Addiction	○ Hepatitis B or C	○ Renal Dialysis
○ Anemia	○ Easily Winded	○ Herpes	○ Rheumatic Fever
○ Angina	○ Emphysema	○ High Blood Pressure	○ Rheumatism
○ Arthritis/Gout	○ Epilepsy/Seizures	○ High Cholesterol	○ Scarlet Fever
○ Artificial Heart Valve	○ Excessive Bleeding	○ Hives or Rash	○ Shingles
○ Artifical Joint	○ Excessive Thirst	○ Hypoglycemia	○ Sickle Cell Disease
○ Asthma	○ Fainting Spells/Dizziness	○ Irregular Heartbeat	○ Sinus Trouble
○ Blood Disease	○ Frequent Cough	○ Kidney Problems	○ Spina Bifida
○ Blood Transfusion	○ Frequent Diarrhea	○ Leukemia	○ Stomach/Intestine Disease
○ Breathing Problems	○ Frequent Headaches	○ Liver Disease	○ Stroke
○ Bruise Easily	○ Genital Herpes	○ Low Blood Pressure	○ Swelling of Limbs
○ Cancer	○ Glaucoma	○ Lung Disease	○ Thyroid Disease
○ Chemotherapy	○ Hay Fever	○ Mitral Valve Prolapse	○ Tonsillitis
○ Chest Pains	○ Heart Attack/Failure	○ Osteoporosis	○ Tuberculosis
○ Cold Sores/Fever Blisters	○ Heart Murmur	○ Pain in Jaw Joints	○ Tumors or Growths
○ Congenital Heart Disorder	○ Heart Pacemaker	○ Parathyroid Disease	○ Ulcers
○ Convulsions	○ Heart Trouble/Disease	○ Psychiatric Care	○ Venereal Disease
○ Yellow Jaundice	○ **OTHER**: _____		

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 responsibilty to inform dental office of any changes in medical status.

Signature of patient, parent or guardian: _____ **Date:** _____

ALLRED DENTISTRY

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgment

I, _____, have received a copy of this office's Notice of Privacy Practices.

***Signature** ***Date**

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgment
- An emergency prevented us from obtaining acknowledgement
- Other (Please specify)

List any individuals you allow us to disclose personal/health information with (including but not limited to diagnoses, labs, prognosis, treatment, billing, personal contact information, and all conditions)

NAME/DOB	CONTACT PHONE NUMBER	RELATIONSHIP TO PATIENT

***SIGNATURE OF PATIENT/PARENT/LEGAL GUARDIAN** ***DATE**

ALLRED
DENTISTRY

MISSED AND LATE APPOINTMENT POLICY

At Allred Family Dentistry, when you make an appointment, a specific amount of time is reserved especially for you. Many offices will double or even triple book appointments to prevent from being financially damaged as a result of a missed appointments. However, overbooking appointments does not allow us to give the care and attention needed to provide quality dentistry and for this reason, we choose not to do this. We trust that you, as our patient, will respect the time our doctors have reserved to see you.

Cancel or change your appointment: If for any reason you must cancel/change your appointment, it is important that you give our office at least 48hrs notice. This gives us the opportunity to offer that spot to someone else and allows us to better serve other patients in need of dental work. Our doctors' times are highly requested, and we want to make sure that our patients don't have to wait for months to be treated.

Late arrival: When we reserve time for you, we require all that time to provide you with the best quality work possible. When you are late, it decreases our ability to accomplish this. If you arrive late, your appointment may be rescheduled.

Missed appointment: After a missed appointment, foryou to schedule a future appointment, a $50.00 deposit must be made. When you arrive to your scheduled appointment, this will be credited back to you. If the second appointment is failed, the deposit is non-refundable.

FINANCIAL POLICIES

ALL PAYMENT IS DUE AT TIME OF SERVICE

Payment is required at the time services are rendered. This includes applicable coinsurance, copayments, deductibles and past due balances. We accept Cash, VISA, MasterCard, Discover, American Express and CareCredit. **WE DO NOT ACCEPT CHECKS**. We use a collection agency to pursue accounts with past due balances of 90 days or more.

INSURANCE: We bill insurance as a courtesy to you. **WE ARE ONLY IN NETWORK WITH CIGNA PPO, METLIFE PPO, DELTA DENTAL PPO, & GUARDIAN PPO**. Benefits and eligibility will be confirmed prior to any procedure. An estimate will be given to you for all procedures. This is only an estimate and not a guarantee of coverage. Changes to your treatment during your procedure may alter the cost of your care. Because this is an estimate, after your claim is paid by the insurance company, you may receive a bill or refund from us. It is your responsibility to know your coverage.

You are responsible for any portion not covered by your insurance.

Please sign below to indicate that you have read and agree to the above policies.

***Signature** ***Date**

Patient Screening Form

Patient Name:

	PRE-APPOINTMENT	IN-OFFICE
	Date:	Date:
Do you/they have fever or have you/they felt hot or feverish recently (14-21 days)?	☐ Yes ☐ No	☐ Yes ☐ No
Are you/they having shortness of breath or other difficulties breathing?	☐ Yes ☐ No	☐ Yes ☐ No
Do you/they have a cough?	☐ Yes ☐ No	☐ Yes ☐ No
Any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue?	☐ Yes ☐ No	☐ Yes ☐ No
Have you/they experienced recent loss of taste or smell?	☐ Yes ☐ No	☐ Yes ☐ No
Are you/they in contact with any confirmed COVID-19 positive patients? *Patients who are well but who have a sick family member at home with COVID-19 should consider postponing elective treatment.*	☐ Yes ☐ No	☐ Yes ☐ No
Is your/their age over 60?	☐ Yes ☐ No	☐ Yes ☐ No
Do you/they have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders?	☐ Yes ☐ No	☐ Yes ☐ No
Have you/they traveled in the past 14 days to any regions affected by COVID-19? (as relevant to your location)	☐ Yes ☐ No	☐ Yes ☐ No

Positive responses to any of these would likely indicate a deeper discussion with the dentist before proceeding with elective dental treatment.

- For testing, see the list of State and Territorial Health Department Websites for your specific area's information.