



David M. Allen, D.D.S. & Associates

4041 Parnell Avenue • Fort Wayne, IN 46805
(260) 482-8386

DATE _____

LAST NAME _____ FIRST _____ MIDDLE _____ (Patient) [] MALE [] FEMALE

HOME PHONE (____) _____ WORK PHONE (____) _____ EXT. _____ CELL PHONE (____) _____

HOME ADDRESS _____ CITY _____ STATE _____ ZIP _____

BIRTHDATE _____ EMAIL ADDRESS _____

SOCIAL SECURITY # _____ [] SINGLE [] MARRIED [] DIVORCED [] SEPARATED [] WIDOWED

EMPLOYER _____ ADDRESS _____

OCCUPATION _____ YEARS EMPLOYED _____

SPOUSE'S NAME _____ EMPLOYER _____ YEARS EMPLOYED _____

SOCIAL SECURITY # _____ WORK PHONE (____) _____

If parents are responsible for bill, fill out parent information:

FATHER _____ ADDRESS (if different) _____ CITY _____ STATE _____ ZIP _____

SOCIAL SECURITY# _____ HM PHONE (____) _____ WK PHONE (____) _____ BIRTHDATE _____

EMPLOYER _____ ADDRESS _____ OCCUPATION _____

MOTHER _____ ADDRESS (if different) _____ CITY _____ STATE _____ ZIP _____

SOCIAL SECURITY# _____ HM PHONE (____) _____ WK PHONE (____) _____ BIRTHDATE _____

EMPLOYER _____ ADDRESS _____ OCCUPATION _____

If person other than parents is responsible for patient's bill, fill out following information:

NAME _____ ADDRESS (if different) _____ CITY _____ STATE _____ ZIP _____

SOCIAL SECURITY# _____ HM PHONE (____) _____ WK PHONE (____) _____ BIRTHDATE _____

EMPLOYER _____ ADDRESS _____ OCCUPATION _____

PRIMARY INSURANCE

NAME OF INSURED PERSON _____ RELATION TO PATIENT _____

SOCIAL SECURITY# _____ DATE OF BIRTH _____

EMPLOYER _____ POLICY# _____

INSURANCE COMPANY NAME _____ GROUP# _____

SECONDARY INSURANCE

NAME OF INSURED PERSON _____ RELATION TO PATIENT _____

SOCIAL SECURITY# _____ DATE OF BIRTH _____

EMPLOYER _____ POLICY# _____

INSURANCE COMPANY NAME _____ GROUP# _____

CONSENT

The undersigned authorizes David M. Allen, D.D.S., d/b/a/ David M. Allen D.D.S., and Associates P.C./Afdent Dental Services ("Afdent") and/or such associates or assistants designated by Afdent to perform those procedures as may be deemed necessary or advisable to maintain the dental health of the undersigned, or the dental health of any minor or other individual for whom the undersigned has responsibility, including the arrangement and/or administration of any sedative, anesthetic, analgesic, therapeutic and/or pharmaceutical agent. The undersigned further authorizes Afdent to take x-rays, study models, photographs and/or other diagnostic measures to perform the treatment, care, and therapy, including the use and provision of medication, which Afdent deems appropriate in connection with treatment provided. The undersigned hereby acknowledges and understands that the use of anesthetic agents embodies certain risks and may cause certain untoward side effects including, but not necessarily limited to, bruising, hematoma, cardiac stimulation, muscle soreness, temporary or permanent numbness. The undersigned hereby voluntarily assumes any and all possible risks, if any, which may be associated with treatment, and further acknowledges that he/she is aware of any potential risks, and has had the opportunity to ask questions in connection with treatment and/or any risk involved. Lastly, the undersigned acknowledges that from time to time it may be necessary to communicate directly with our patients and customers. In this regard, in an effort to maintain the highest level of customer service, it is Afdent's policy to record or monitor client communications including telephone calls. By executing this form, the undersigned acknowledges Afdent's recording policy and consents to the recording and/or monitoring of his/her communications with Afdent. This consent shall be valid and continue until the undersigned revokes same by sending written notice to Afdent at the above address.

PATIENT _____ DATE _____ WITNESS _____

PARENT OR OTHER RESPONSIBLE PARTY _____ RELATIONSHIP TO PATIENT _____

PREVIOUS DENTIST'S NAME _____

PHYSICIAN'S NAME _____ PHONE (____) _____

SPECIALIST'S NAME _____ PHONE(____) _____

REFERRED BY? Family _____ Friend _____ Phonebook _____ Dr. _____ Radio _____

TV _____ 1-800-TOOTHACHE Newspaper Billboard Sign Website Other _____

IF REFERRED: NAME _____ PHONE (____) _____

In case of emergency, nearest relative not living with you.

NAME _____

ADDRESS _____

PHONE (____) _____ RELATIONSHIP _____

MEDICAL HISTORY RECORD

Are you taking any medication, pills, or drugs? Yes No N/A _____

Have you been hospitalized or had a major operation in the last 2 years? Yes No N/A _____

Are you under a physician's care now? Yes No N/A _____

Have you ever had excessive bleeding with previous extractions? Yes No N/A _____

Are you currently taking a blood thinner? Yes No N/A _____

Do you have a denture or partial denture? Yes No N/A _____

Do you use tobacco? Yes No N/A _____

Women: Are you Pregnant/Trying to get pregnant? Nursing? Taking oral contraceptives?

Are you allergic to any of the following? _____

Aspirin Penicillin Codeine Sulfa Latex Acrylic Metal Local Anesthetics Other _____

Have you ever been treated for or informed you have: _____

- | | | |
|--|--|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Kidney Problems |
| <input type="checkbox"/> Artificial Heart Valve* | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Artificial Joints* | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Low Blood Pressure |
| <input type="checkbox"/> Artery Stents* | <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Mitral Valve Prolapse* |
| <input type="checkbox"/> Asthma Do you carry an inhaler? _____ | <input type="checkbox"/> Fainting Spells | <input type="checkbox"/> Psychiatric Care |
| <input type="checkbox"/> Blood Tranfusion When? _____ | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Radiation Treatments |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Rheumatic Fever* |
| Areas of Body: _____ | <input type="checkbox"/> Heart Attack / Failure | <input type="checkbox"/> Sinus Trouble |
| _____ | <input type="checkbox"/> Heart Murmur* | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Heart Pace Maker* When? _____ | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Heart Trouble / Disease | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Cortisone Medicine | <input type="checkbox"/> Hepatitis A B C | <input type="checkbox"/> Ulcers |
| | <input type="checkbox"/> HIV Positive | <input type="checkbox"/> Venereal Disease |

Have you ever had any serious illness not listed above? Yes No If yes, please explain: _____

The undersigned hereby certifies that the answers to the health questions herein are accurate and correct to the best of his/her knowledge. Since a change of medical condition or medications can affect dental treatment, the undersigned understands the importance of the information provided herein and agrees to notify Afdent in the event of any change thereof. The undersigned certifies and agrees that he/she shall be responsible for payment for all dental services provided by Afdent, and that payment shall be due and payable at the time dental services are provided unless otherwise agreed in writing. The undersigned further agrees and acknowledges that a monthly finance charge of 1.75% (21% annually) will be applied to all amounts not paid at the time of treatment. The undersigned also agrees and acknowledges that a \$30.00 late fee per month shall be added on all past due accounts. The undersigned shall pay to Afdent all costs associated with collecting any and all past due amounts including court costs and reasonable attorneys' fees. Upon request, Afdent will submit invoices for services rendered for payment to the employer, insurance carrier, insurance provider or union office of the undersigned for payment and/or reimbursement. However, the undersigned shall be completely responsible to Afdent for payment at the time of treatment regardless of any third party obligation.

I have read and I understand the above, I certify the above medical information is complete and correct.

Patient or Parent Signature: _____ Date _____ / _____ / _____