**David M. Allen, D.D.S. & Associates**
4041 Parnell Avenue • Fort Wayne, IN 46805
(260) 482-8386

DATE _____

LAST NAME: _____ FIRST: _____ MIDDLE: _____ ☐ MALE ☐ FEMALE

HOME PHONE: (___)_____ WORK: (___)_____ CELL: (___)_____

PREFERRED METHOD OF CONTACT: (PLEASE CHECK ALL THAT APPLY)

☐ HOME PHONE ☐ WORK PHONE ☐ CELL PHONE ☐ TEXT ☐ EMAIL: _____

HOME ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

BIRTHDATE: _____ SOCIAL SECURITY #: ___-___-___

EMPLOYER: _____ ADDRESS: _____

OCCUPATION: _____ YEARS EMPLOYED: _____

SPOUSE'S NAME: _____ EMPLOYER: _____ YEARS EMPLOYED: _____

SPOUSE'S SOCIAL SECURITY #: ___-___-___ WORK PHONE: (___) _____ CELL #: (___) _____

***If parents are responsible for bill, fill out the 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: _____

***In case of emergency, nearest relative not living with you:***

NAME: _____ RELATIONSHIP: _____

HOME PHONE: (___)_____ WORK: (___)_____ CELL: (___)_____

ADDRESS: _____

## 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 _____



*PLEASE COMPLETE OTHER SIDE.*

LAST DENTAL VISIT:_____

REFERRED BY (please share with us how you heard about our office)

○ Family ○ Friend ○ Dr. _____ ○ Phonebook _____ ○ TV _____

○ Radio _____ ○ 1-800-TOOTHACHE ○ Newspaper ○ Billboard ○ Sign ○ Website ○ Other: _____

NAME OF PERSON THAT REFERRED YOU: _____

## MEDICAL HISTORY RECORD

PREVIOUS DENTIST'S NAME: _____ PHONE (____) _____

PHYSICIAN'S NAME: _____ PHONE (____) _____

SPECIALIST'S NAME _____ PHONE (____) _____

Are you currently under the care of a Pain Management doctor? ○ Yes ○ No _____

Are you taking any medication, pills, or drugs? ○ Yes ○ No _____

(Please list any prescription or over the counter medications) _____

_____

Have you ever taken a Bisphosphonate medication? ○ Yes ○ No

Are you currently taking a blood thinner? ○ Yes ○ No _____

Are you now or have you ever taken Methadone? ○ Yes ○ No _____

Are you currently under the care of a physician? ○ Yes ○ No _____

Do you have denture or partial denture? ○ Yes ○ No How old? _____

Do you use tobacco? How Much Per Day_____ ○ Yes ○ No _____

Women: Are you ○ Pregnant/Trying to get pregnant: If pregnant: How far along? _____ Due Date: _____

○ 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 or informed you have:

- ☐ AIDS
- ☐ Arthritis
- ☐ Artificial Heart Valve*
- ☐ Artificial Joints*
- ☐ Artery Stents*
- ☐ Asthma Do you carry an inhaler?
- ☐ Blood Transfusion When? _____
- ☐ Cancer Areas of Body:_____
- ☐ Chemotherapy When? _____
- ☐ Chest Pain
- ☐ Cortisone Medicine
- ☐ C.O.P.D. (Chronic Bronchitis or Emphysema)
- ☐ Diabetes
- ☐ Drug Addiction
- ☐ Eating Disorder
- ☐ Epilepsy or Seizures
- ☐ Fainting Spells
- ☐ Glaucoma
- ☐ Heart Attack / Failure / Disease
- ☐ Heart Murmur*
- ☐ Heart Pace Maker* When?_____
- ☐ Hepatitis A B C
- ☐ HIV Positive
- ☐ High Blood Pressure
- ☐ Kidney Problems
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Mitral Valve Prolapse*
- ☐ Osteoporosis
- ☐ Psychiatric care
- ☐ Radiation Treatments
- ☐ Rheumatic Fever*
- ☐ Sinus Trouble / Hay Fever
- ☐ Sleep Apnea Do you use a CPAP?
- ☐ Stroke When?_____
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Ulcers

For office use:

Premed needed?_____

Have you ever had any serious illness not listed above, or have you been hospitalized in the past two years? ○ 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 $18.00 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 _____ / _____ / _____

Afdent
David M. Allen and Associates™
4041 Parnell Avenue • Ft. Wayne, IN 46805 • (260) 482-8386
(800) 253-1668 • Fax (260) 483-0024

## CONSULTATION PATIENTS

I UNDERSTAND THAT TODAY'S VISIT IS A FREE CONSULTATION. AS PART OF TODAY'S APPOINTMENT, I WILL HAVE X-RAYS TAKEN AND AN EXAM TO ALLOW THE DOCTOR TO DIAGNOSE TREATMENT NECESSARY. THE EXAM AND X-RAYS ARE INCLUDED IN THE CONSULTATION AND ARE AT NO CHARGE TO ME TODAY. **IF I CHOOSE TO ACCEPT AND BEGIN TREATMENT AT AFDENT THE APPROPRIATE FEES FOR THE EXAM AND X-RAYS WILL BE INCLUDED IN THE TOTAL FEE OF TREATMENT NECESSARY TO ME.**

I UNDERSTAND THAT WITHOUT X-RAYS AND AN EXAM THE DOCTOR DOES NOT HAVE ALL THE INFORMATION AVAILABLE TO HIM TO GIVE ME A COMPLETE DIAGNOSIS OF MY DENTAL HEALTH.

SIGNATURE OF PATIENT _____ DATE _____

**Patient Records Access Request Form**

David M. Allen, D.D.S. & Associates, P.C.
4041 Parnell Avenue
Fort Wayne, IN 46805
(260) 482-8386 phone
(260) 483-0024 fax

I hereby request a copy of my medical record as detailed below:

- ☐ Full medical record held by this office
- ☐ Medical record for the period _____ through _____.
- ☐ A specific portion/section of the record as follows:

_____

_____

_____

***I understand that, unless otherwise provided by law, the charge for this record will be $0.25 per page for each page copied. I agree to pay this charge in full at the time I receive the copy of the record.***

| Patient Name: | |
|---|---|
| Name: | Relationship: |
| Signature: | Date: |

Afdent
David M. Allen and Associates™
4041 Parnell Avenue • Ft. Wayne, IN 46805 • (260) 482-8386
(800) 253-1668 • Fax (260) 483-0024

# EMERGENCY PATIENTS/ PATIENTS SEEKING TREATMENT

I UNDERSTAND THAT TODAY'S VISIT IS NOT A CONSULTATION AND THAT I CAN SCHEDULE AN APPOINTMENT FOR A FREE CONSULTATION ANYTIME AFTER TODAY'S EMERGENCY VISIT.

## PATIENTS WITH INSURANCE:

IF I HAVE DENTAL INSURANCE, I WILL BE RESPONSIBLE FOR MY INSURANCE POLICY'S DEDUCTIBLE AT THE TIME OF SERVICE. I WILL ALSO PAY ANY REMAINING BALANCE NOT COVERED BY THE INSURANCE.

## SELF PAY PATIENTS:

IF NO INSURANCE IS INVOLVED, I AM EXPECTED TO PAY MY CHARGES AT THE TIME OF SERVICE UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE WITH THE FINANCE OFFICE.

AS AN EMERGENCY PATIENT AT AFDENT, I UNDERSTAND THAT I AM EXPECTED TO PAY $200.00 TODAY AND FURTHER FINANCIAL ARRANGEMENTS WILL BE FULLY DISCUSSED WITH ME PRIOR TO INITIATING TREATMENT.

SIGNATURE OF PATIENT _____ DATE _____