Patient Registration

About you

Name: _____ (Last) _____ (First) _____ (Mid)

I prefer to be called: _____

Your birthday: __/__/____ Age:_____ SSN: ___-___-_____ Sex: _____

Home address: _____

City: _____ State: _____ Zip: _____APT#: _____

Email address: _____

Marital Status : ☐ Single ☐ Married ☐ Divorced/Separated ☐ Widowed ☐ Partnered

Home phone #: (___) - ___ - ____ Cell Phone #: (___) - ___ - ____

Work Phone #: (___) - ___ - ____ Ext: _____

Employer: _____

Employer address : _____

City:_____ State: _____ Zip: _____ APT# : _____

How long there? _____

Occupation : _____

Where & when are best times to reach you? _____

How did you hear about us? _____

Have you visited our website? ☐ Yes ☐ No

Whom may we thank for referring you? _____

_____

Other family members seen by us: _____

_____

_____

_____

_____

Previous dentist: _____

Person responsible for account: _____

Spouse information

His / Her name: _____

Employer: _____

Work Phone #: (___) - ___ - ____ Ext: _____ Birthday : __/__/____

Cell Phone #: (___) - ___ - ____ Social Security #: ___-___-_____

Relative or friend not living with you

His / Her name: _____

Relationship: _____

Home Phone #: (___) - ___ - ____ Cell Phone #: (___) - ___ - ____

Medical insurance information

Insurance Co. name: _____

Insurance Co. Address: _____

City: _____ State: _____ Zip: _____

Insurance Co. Phone: (___) - ___ - ____

Group# (Plan, Local or Policy#):_____

Insured's name: _____

Relationship: _____

Insured's Birthday: __/__/____ SSN: ___-___-_____

Dental insurance information

Primary insurance

Dental coverage? ☐ Yes ☐ No

Insurance Co. name: _____

Insurance Co. Address: _____

City: _____ State: _____ Zip: _____

Insurance Co. Phone #: (___) - ___ - ____

Group# (Plan, Local or Policy#):_____

Insured's name: _____

Relationship: _____

Insured's Birthday: __/__/____

Insured's ID: _____

Insured's employer: _____

Employer Address: _____

City: _____ State: _____ Zip: _____

Secondary insurance

Dental coverage? ☐ Yes ☐ No

Insurance Co. name: _____

Insurance Co. Address: _____

City: _____ State: _____ Zip: _____

Insurance Co. Phone: (___) - ___ - ____

Group# (Plan, Local or Policy#):_____

Insured's name: _____

Relationship: _____

Insured's Birthday: __/__/____

Insured's ID: _____

Payment is due in full at the time of treatment

Unless prior arrangements have been approved.

I agree: ☐ Yes ☐ No

I understand that I am responsible for payment of service rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all cost of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

Medical History

Physician's Name: _____

Telephone home: (___) - ___ - ____ Date of last visit: __/__/____

Your current physical health is: ☐ Good ☐ Fair ☐ Poor

Ever been hospitalized? ☐ Yes ☐ No

Do you drink alcohol? ☐ Yes ☐ No Do you use drugs? ☐ Yes ☐ No

If so which ones? _____

Any trouble with prior surgeries? ☐ Yes ☐ No

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

Please explain:_____

_____

_____

Do you smoke or use tobacco in any other form? ☐ Yes ☐ No

Have you had any metal rods, pins or implants? ☐ Yes ☐ No

Are you taking any prescription / Over-the-counter drugs? ☐ Yes ☐ No

Please explain: _____

_____

_____

Have you ever taken Fosamax, or any other bisphosphonate? ☐ Yes ☐ No

Have you ever taken Phen-fen? ☐ Yes ☐ No

Is your mouth dry? ☐ Yes ☐ No

Do you have any type of hearing impairment? ☐ Yes ☐ No

Do you wear contact lenses? ☐ Yes ☐ No

For women: Are you using a prescribed method of birth control? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No Week #: _____

Are you nursing? ☐ Yes ☐ No

Please list all medication/drugs that you are currently taking :

_____

_____

_____

Please list any serious medical condition(s) that you have ever had :

_____

_____

_____

Are you allergic to any of the following?

☐ Yes	☐ No	Aspirin	☐ Yes	☐ No	Erythromycin
☐ Yes	☐ No	Penicillin	☐ Yes	☐ No	Codeine
☐ Yes	☐ No	Jewelry / Metals	☐ Yes	☐ No	Tetracycline
☐ Yes	☐ No	Dental anesthetics	☐ Yes	☐ No	Latex
☐ Yes	☐ No	Other	☐ Yes	☐ No	Any Nuts

Please list any other drugs / Materials that you are allergic to :

_____

_____

_____

Have you ever had any of the following diseases or medical problems

Yes	No		Yes	No	
☐	☐	Abnormal Bleeding / Hemophilia	☐	☐	Heart Disease
☐	☐	Herpes / Fever blisters	☐	☐	AIDS
☐	☐	Alcohol / Drug abuse	☐	☐	High blood pressure
☐	☐	Anemia	☐	☐	HIV
☐	☐	Arthritis	☐	☐	Kidney problems
☐	☐	Artificial bones / Joints / Valves	☐	☐	Liver disease
☐	☐	Asthma	☐	☐	Low blood pressure
☐	☐	Blood transfusion	☐	☐	Lupus
☐	☐	Cancer / Chemotherapy	☐	☐	Mitral valve prolapse
☐	☐	Colitis	☐	☐	Pacemaker
☐	☐	Radiation treatment	☐	☐	Psychiatric problems
☐	☐	Diabetes	☐	☐	Congenital heart defect
☐	☐	Difficulty breathing	☐	☐	Rheumatic / Scarlet fever
☐	☐	Emphysema	☐	☐	Seizures
☐	☐	Epilepsy	☐	☐	Shingles
☐	☐	Sickle cell disease / Traits	☐	☐	Fainting spells
☐	☐	Frequent headaches	☐	☐	Sinus problems
☐	☐	Glaucoma	☐	☐	Stroke
☐	☐	Hay fever	☐	☐	Thyroid problems
☐	☐	Heart attack / Surgery	☐	☐	Tuberculosis (TB)
☐	☐	Heart murmur	☐	☐	Ulcers
☐	☐	Hepatitis	☐	☐	Aneurysm
☐	☐	Angina	☐	☐	Respiratory Problem
☐	☐	Head injury	☐	☐	STD

Dental history

Why have you come to the dentist today? _____

_____

_____

Date of your last dental visit : __/__/____

Date of your last dental cleaning : __/__/____

Date of last full mouth series of x-rays : __/__/____

Are you currently in pain? ☐ Yes ☐ No

Do you require antibiotics before dental treatment? ☐ Yes ☐ No

Your current dental health is : ☐ Good ☐ Fair ☐ Poor

Dental history (Continued)

Have you ever had a serious/difficult problem associated with any previous dental work? ☐ Yes ☐ No

Do you floss daily? ☐ Yes ☐ No Brush daily? ☐ Yes ☐ No

Type of bristles on your toothbrush? ☐ Yes ☐ No

Have you ever had gum treatment? ☐ Yes ☐ No

Do your gums ever bleed? ☐ Yes ☐ No Ever Itch? ☐ Yes ☐ No

Have you ever had periodontal disease? ☐ Yes ☐ No

Do you now or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)? ☐ Yes ☐ No

Are your teeth sensitive to hot, cold, sweets or anything else? ☐ Yes ☐ No

Any problems with Jaw? ☐ Yes ☐ No Mouth breather? ☐ Yes ☐ No

Do you have any loose teeth? ☐ Yes ☐ No

Do you still have wisdom teeth? ☐ Yes ☐ No

Would you like fresher breath? ☐ Yes ☐ No

Whiter teeth? ☐ Yes ☐ No

Does food tend to become caught between your teeth? ☐ Yes ☐ No

Do your gums often bleed when you brush your teeth ? ☐ Yes ☐ No

Have you ever had jaw surgery or a broken jaw ? ☐ Yes ☐ No

Do you clench or grind your teeth while awake or asleep? ☐ Yes ☐ No

Do you snore ? ☐ Yes ☐ No

Do you feel very nervous about having dental treatment? ☐ Yes ☐ No

Have you ever had an upsetting experience in a dental office? ☐ Yes ☐ No

Is there anything else about having dental treatment that bothers you ? ☐ Yes ☐ No

Do you expect to eventually lose your teeth? ☐ Yes ☐ No

Are you dissatisfied with the appearance of your teeth ? ☐ Yes ☐ No

Do you feel your teeth are crowded or crooked ? ☐ Yes ☐ No

Do you feel your teeth are yellow, dark or stained ? ☐ Yes ☐ No

Do you feel your smile could be improved ? ☐ Yes ☐ No

Would you like to discuss improving your smile at today's appointment ☐ Yes ☐ No

If yes to any of these questions, please explain _____

_____

_____

Are you happy with the way your smile looks? ☐ Yes ☐ No

If not, what would you change? _____

_____

_____

Have you ever had

Yes / No		Yes / No	
☐	Orthodontic treatment	☐	Periodontal treatment
☐	Oral surgery	☐	Worn a bite plate

I agree: ☐ Yes ☐ No

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail. If deemed advisable, I grant permission for my physician to be contacted for details and advice. For evaluation or teaching purposes I authorize the use of my radiographs or photographs. Authorization is also given for dental treatment to be rendered by the dentist and office staff, and I will assume financial responsibility.

Signature: _____ Date: _____

OFFICE USE ONLY OFFICE USE ONLY

I verbally reviewed the medical / dental information with the patient named herein.

Initials:_____ Date:_____

Doctor's Comments:_____

_____

_____

_____

_____

Allure Family Dental
& SPECIALTY GROUP

Written Financial Policy

Thank you for choosing Allure Family Dental Group or Allure Dental Specialist of Huntington Beach. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:

You can choose from:

- Cash, Check, Visa, MasterCard, Debit Card or American Express
- Convenient Monthly Payment Options[i] from Care Credit
    - Allow you to pay over time
    - No Annual fees or pre-payment penalties

Please note:

Allure Family Dental Group and Allure Dental Specialist of Huntington Beach requires payment prior to the completion of your treatment. If you choose to discontinue care before treatment is complete, your refund will be determined upon review of your case.

For patients with dental insurance we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment on your behalf.[ii]

A fee of $50.00 is charged for patients who miss or cancel more than 1 time in a calendar year without 24 hour notice.

Allure Family Dental Group and Allure Dental Specialist of Huntington Beach charges 50.00 for returned checks.

If you have any questions please do not hesitate to ask. We are here to help you get the dentistry you want or need.

Patient, Parent or Guardian Signature Date

Patient Name (Please Print)

[i]Subject to credit approval

[ii]However, if we do not receive payment from your insurance carrier within 30 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.

Allure Family Dental
& SPECIALTY GROUP

18593 Beach Blvd • Huntington Beach, CA 92648

714-581-8989 • 714-581-8889 Fax

Acknowledgement of Receipt

Of Notice of Privacy Practices

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

Print Name: _____

Signature _____

You may refuse to sign this Acknowledgement

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

□ Communications barriers prohibited obtaining the acknowledgement

□ An emergency situation prevented us from obtaining acknowledgement

□ Other (Please Specify)

_____

_____

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UNDERSTANDING YOUR MANAGED CARE DENTAL PLAN (HMO)

Capitation or Managed Care (HMO) Plan

These plans are sometimes called health maintenance organizations (HMO's). In this type of plan, the doctor is on a contractual agreement to treat members enrolled in the plan. The doctor, in return, has agreed to render the treatment that the patient may require for the listed co-payment provided the plan covers the treatment. Payment is due in full and payable when the services are rendered. The patient may see only a participating doctor.

Under this maintenance organization (HMO) we do not bill or send any insurance claims to your HMO for further payment. If you are seeing a specialist some HMO plans do have reimbursement to bring down your cost and we will gladly bill for those procedures that are covered. We will not send claims for services that are listed as not covered by your plan. You are responsible for the specific patient co-pay as listed in your handbook which is a greatly reduced fee. Our front office staff will be happy to go over all charges and co-payments before any treatment is performed.

All member's names are shown on the patient roster in an active status for the entire month.

All members are responsible for payment if found ineligible for benefits

Cancelled or failed appointments without a 24 hour notice will result in a charge of 50.00. Please refer to your handbook.

Patient Signature_____ Date_____

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& SPECIALTY GROUP

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UNDERSTANDING YOUR DENTAL PLAN

Indemnity or PPO Insurance

I hereby assign my insurance benefits to be made directly to my doctor for services rendered. I hereby attest that the insurance information I have provided is accurate and that I am responsible for knowing my benefit and /or coverage. I will be financially responsible for all charges that are not covered by my insurance company. I also herby authorize the release of all information to other dentist and insurance carriers upon request for the purpose of payment for dental services and further treatment of care by another specialist. I further agree that a photocopy of this agreement shall be valid as the original. All charges are the direct responsibility of the patient. I understand that the services cannot be rendered on the assumption that charges will be paid by the insurance company and that the insurance is an agreement me and my insurance company. If there are problems collecting payment(s) attorney's fees, collection agency costs and any related fees will be added to my bill. I hereby acknowledge that I have read, understand and agrees to asses, treat and test.

All members are responsible for payment if found ineligible for benefits.

Cancelled or failed appointments without a 24 hour notice will result in a 50.00 cancellation charge. Please refer to your handbook.

We bill your insurance as a courtesy and convenience to you.

Patient Signature_____ Date_____

Allure Family Dental
& SPECIALTY GROUP

Patient-Dentist Arbitration Agreement

Article I.

It is understood that any dispute as to dental malpractice, this, as to whether any dental services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, would be determined by submission to arbitration as provided by California Law, and not by a lawsuit, or resort to court process, except as California law provides for judicial review or arbitration proceedings. Both parties of this contract by entering into it, have given up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Treatment in this office is contingent upon both parties consenting to this Arbitration Agreement.

Article II.

A. Parties to the Agreement:
The term "patient" as used in this agreement includes the undersigned individual, his or her spouse, children (whether born or unborn), and heirs, assigns or personal representatives. The individual signing this Agreement signs it on behalf of the foregoing persons, and intends to bind each of them to arbitration to the full extent permitted by law.
The term "doctor" as used in this agreement includes the undersigned doctor and his or her professional corporation or partnership, and any employees, agents, successors in interest, heirs and assigns of the foregoing individuals or entities and independent contractors. The doctor signing this agreement signs it on behalf of all the foregoing individual and entities, and intends to bind each of them to arbitration to full extent permitted by law.
B. Treatment Covered:
Patient understands and agrees that any dispute of the sort descried in Article I between doctor and patient will be subject to compulsory, binding arbitration.
C. Coverage of Pre-Natal Claims (If Applicable):
Patient understands and agrees that, if doctor treats her during pregnancy, any dispute or sort descried in Article I as to dental treatment rendered to or affecting the unborn child will be subject to compulsory, binding arbitration.

Article III.

A. Informal Resolution of Disputes:
In the event patient feels that a problem has arisen in connection with the dental care rendered by doctor to patient, patient will promptly notify doctor so that doctor may have the opportunity to resolve the matter. Notice may be given orally or in writing, and shall stop the running or statute of limitations forninety (90) days.
B. Method of Initiating Arbitration:
If the dispute is not resolved by mutual Agreement within ninety (90) days, patient may initiate arbitration by notifying doctor to that affect. The arbitrator shall be selected by the chief administrator of JAMS ENDISPUTE. The arbitrator must be selected within twenty-one (21) days of the signature on the receipt for a letter sent certified mail return receipt request demanding that a dispute submitted to arbitration. Following the selection of the arbitrator, arbitration must be held within thirty (30) days.
C. Applicable Law:
The arbitration shall be conducted pursuant the California Arbitration Act (C.C.P. 1280-1296). The Arbitrator shall, in addition, have authority to order such other discovery as he/she deemed appropriate for a full and fair hearing of the case. A determination on the merits shall be rendered in accordance with the law of the State of California, including the provisions of the Medical Injury Compensation Reform Act 1975 which shall apply to the same extent as if to dispute or pending before a Superior Court of the State of California.
The arbitrator shall not have the power to commit errors of law or legal reasoning, and the arbitrator's decision may be vacated or corrected pursuant the California Code of Civil Procedure Sections 12806.2 or 12086.6 for any such error.
The prevailing party shall be entitled to attorney fees.

Article IV.

A. Revocation:
If you are signing this agreement and then change your mind, the law permits you to revoke the Agreement providing you give your doctor written notice within thirty (30) days of signing that you want to withdraw from the Agreement. However, doctor and patient agree that any claim arising for dental services rendered prior to revocation shall be subjected to arbitration. Furthermore, doctor is not obligated to continue the doctor/patient relationship should you decide to withdraw from the agreement.
NOTICE: BY SIGNING THIS CONTRACT, YOU ARE AGREEING TO HAVE ANY ISSUE OF DENTAL MALPRACTICE DECIDED BY MUTUAL ARBITRATION AND YOU ARE GIVING UP RIGHT TO JURY OR COURT TRIAL, SEE ARTICLE I OF THIS CONTRACT.

PATIENT'S NAME: (Please Print):_____
DATE:_____

SIGNED: _____

SIGNED: _____
Patient/Legal Guardian

SIGNED: _____
Witness