



Allure Dental, LLC  
 171 Elden Street, Suite 2C3  
 Phone: 703-956-6168 Fax: 703-964-9899  
 www.alluredentalservices.com

**Patient Information (Confidential)**

E-mail Address: \_\_\_\_\_  
 Name: \_\_\_\_\_ Nickname: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
 Address: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
 Soc. Sec. # \_\_\_\_\_ Employer: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Male  Female   
 Emergency Contact Name: \_\_\_\_\_ Emergency Contact Phone: \_\_\_\_\_  
 How would you like to be reminded of your appointment:  E-mail  Text  Cell  Work  Home

Marital Status:  Single  Married  Divorced  Widowed  Separated

How did you hear about our office?  Insurance  Internet  Mailer  Referral

**Whom may we thank for the referral?** \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Subscriber ID # \_\_\_\_\_ Group # \_\_\_\_\_ Phone # \_\_\_\_\_

Secondary Ins. Co.: \_\_\_\_\_ Subscriber ID # \_\_\_\_\_ Group # \_\_\_\_\_ Phone # \_\_\_\_\_

**Responsible Party Information:**  Self  Other (fill out next 3 line items)

Name of person responsible for this account: \_\_\_\_\_ Soc. Sec.# \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Phone# \_\_\_\_\_

Address: \_\_\_\_\_ Employer: \_\_\_\_\_

**Authorization Statement and HIPPA Privacy Notice:**

I hereby authorize Allure Dental, LLC and Dr. Ayoubi to provide dental services to me and my dependants and apply for benefits on my behalf for covered services rendered. I request that the payments from my insurance company be made to the above named corporation and/or provider(s). I certify that the information that I have provided above is correct and further authorize the release of any necessary information including medical, dental and insurance coverage information to my insurance company in order to determine my insurance benefits to which I may be entitled. I authorize the provider to initiate a complaint to the Insurance Commissioner for any reason on my behalf. A photocopy of this assignment shall be considered as effective and valid as the original, this authorization may be revoked at any time in writing. I understand and agree that (regardless of my dental insurance status or coverage), I am ultimately responsible for the balance on my account and my dependents for any dental services rendered. If my account becomes past due I agree to pay all costs of collections and litigations if any. I understand that if my account is delinquent I will be charged an additional 33% to cover collection expenses. I have read this entire sheet and have completed the above answers. I certify that this information is true and correct to the best of my knowledge and I will notify Allure Dental, LLC of any changes in my status or the above information.

SIGNATURE OF PATIENT, PARENT OR GUARDIAN \_\_\_\_\_ DATE \_\_\_\_\_

**HIPPA STATEMENT**

I have read and agree with Allure Dental, LLC's HIPPA Notice of Privacy Policy. I hereby authorize Allure Dental, LLC to furnish to my insurance company or authorizing agency information regarding my protected health information for the purposes of treatment, payments, or health care operations. I further authorize the dentist(s) of Allure Dental, LLC to consult as needed in their sole discretion with other medical providers regarding my medical care.

SIGNATURE OF PATIENT, PARENT OR GUARDIAN \_\_\_\_\_ DATE \_\_\_\_\_

*For your convenience, we offer the following methods of payment:  
 Debit Card • MasterCard • Visa • Cash*

***Payment is expected at time of service. Thank you.***

## Patient Medical History

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important impact on dental treatment. Thank you for answering the following questions.

Current Physician Name & Phone #: \_\_\_\_\_  No  Yes Are you currently under their care?

Have you ever been hospitalized or had a major operation?  No  Yes, for what: \_\_\_\_\_

Have you ever had a serious head or neck injury?  No  Yes, what occurred: \_\_\_\_\_

Have you ever had joint replacement?  No  Yes, if yes, when?: \_\_\_\_\_

Do you take, or have you taken, Phen-Fen or Redux?  No  Yes, for how long: \_\_\_\_\_

Have you ever taken Fosamax, Boniva, Actonel or any other medication containing Bisphosphonates?  No  Yes, for how long: \_\_\_\_\_

Are you on a special diet?  No  Yes, which type: \_\_\_\_\_

Do you use tobacco?  No  Yes, how much daily\_\_\_\_, weekly \_\_\_\_\_

Do you use any controlled substances?  No  Yes, which ones: \_\_\_\_\_

**Are you taking any medications, pills or drugs?**  No  Yes, which ones: \_\_\_\_\_

Women: Are you...  Pregnant  Trying to conceive  Nursing  Taking hormonal contraceptives (oral, patch, or other)

Please indicate if you are allergic to any of the following:

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

Please indicate if you have, or have you had, any of the following:

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

Have you ever had a serious illness not listed above?  
Comments:

Yes  No  N/A

\* Condition may require medication.

N/A – Not answered by patient

2007 American Heart Association Guidelines do not require prophylactic antibiotics prior to most procedures. Notify us if you have a special situation.

## Patient Dental History

Name of Previous Dentist and Location \_\_\_\_\_ Date of Last Exam: \_\_\_\_\_

Describe your immediate dental concern: \_\_\_\_\_

	YES	NO		YES	NO
Do your gums bleed while brushing your teeth?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have frequent headaches?	<input type="checkbox"/>	<input type="checkbox"/>
Are your teeth sensitive to hot or cold liquids/foods?	<input type="checkbox"/>	<input type="checkbox"/>	Do you clench or grind your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
Are your teeth sensitive to sweet or sour liquids/foods?	<input type="checkbox"/>	<input type="checkbox"/>	Do you bite your lips or cheeks frequently?	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel pain in any of your teeth?	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had any difficult extractions?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any sores or lumps in or near your teeth?	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had any prolonged bleeding following extractions?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any head neck or jaw injuries?	<input type="checkbox"/>	<input type="checkbox"/>	Have you had any orthodontic treatment?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever experienced any of the following problems in your jaw?	<input type="checkbox"/>	<input type="checkbox"/>	Do you wear dentures or partials?	<input type="checkbox"/>	<input type="checkbox"/>
Clicking	<input type="checkbox"/>	<input type="checkbox"/>	If yes, date of placement:		
Pain (joint, ear, side of face)	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty in opening or closing	<input type="checkbox"/>	<input type="checkbox"/>	Do you like your smile?	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty in chewing	<input type="checkbox"/>	<input type="checkbox"/>			

I certify that I have read and understand all of the above and that I have answered all of the questions accurately. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and records of any treatment or examination rendered to me, or my child, during the period of such dental care to third party payors and/or health practitioners. I hereby authorize Dr. Ayoubi and her staff to examine, take x-rays, and do any necessary treatment. I understand that additional diagnostic procedures and dental treatments may be recommended and will be discussed with me prior to being done. Also, I acknowledge that there are no guarantees, expressed or implied, as to the results of any procedure or dental treatments performed.

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