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 HIIPA 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:

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

Have you ever had a serious illness not listed above? ❑ Yes ❑ No ❑ N/A

Comments:

* 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?	❑	❑	Do you have frequent headaches?	❑	❑
Are your teeth sensitive to hot or cold liquids/foods?	❑	❑	Do you clench or grind your teeth?	❑	❑
Are your teeth sensitive to sweet or sour liquids/foods?	❑	❑	Do you bite your lips or cheeks frequently?	❑	❑
Do you feel pain in any of your teeth?	❑	❑	Have you ever had any difficult extractions?	❑	❑
Do you have any sores or lumps in or near your teeth?	❑	❑	Have you ever had any prolonged bleeding		
Have you had any head neck or jaw injuries?	❑	❑	following extractions?	❑	❑
Have you ever experienced any of the following			Have you had any orthodontic treatment?	❑	❑
problems in your jaw?	❑	❑	Do you wear dentures or partials?	❑	❑
Clicking	❑	❑	If yes, date of placement:		
Pain (joint, ear, side of face)	❑	❑	Have you ever received oral hygiene instructions		
Difficulty in opening or closing	❑	❑	regarding the care of your teeth and gums?	❑	❑
Difficulty in chewing	❑	❑	Do you like your smile?	❑	❑

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.

SIGNATURE OF PATIENT, PARENT OR GUARDIAN_____DATE_____