Welcome

All Care Dental

We are pleased to welcome you to our practice. Please take a few minutes to fill this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Patient Registration

First Name:_____ Last Name:_____ Middle Initial_____

Address:_____City, State, Zip:_____

Birth Date:_____ Driver Lic#:_____ Soc.Sec#:_____

Sex:_____ Marital Status:_____ Employed by:_____
(Male /Female) (Married, Single, Divorced, Widowed, Minor)

Spouse:_____ Birth Date:_____
(Full Name) (Spouse)

Employed by:_____ Referred by:_____
(Spouse)

Contact information

Home#:_____ Cell#:_____ Work#:_____

Email: _____ How did you hear about us: _____

Emergency Contact:_____Phone#:_____Relation:_____
(Full Name)

Insurance

Person Responsible for Account:_____
(Full Name)

Name of Insurance:_____ Subscriber:_____

Group Number:_____ Subscribers Soc. Sec#:_____

D.O.B of Subscriber:_____ Last Dental Visit :_____

Acknowledgement of Receipts of Notice of Privacy Practices

I, _____, have read a copy of this office's Notice Privacy Practices.

_____

(Signature) (Date)

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PHYSICIAN'S NAME_____ ADDRESS_____
PHYSICIAN'S PHONE _____ DATE OF LAST PHYSICAL_____

MANY DISEASES ARE FIRST DIAGNOSED IN THE MOUTH SO WE NEED TO KNOW IF YOU

HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING: (**Check all that Apply**)

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

MEDICATIONS

_____
_____
_____
_____
_____
_____

ALLERGIES

- ☐ Aspirin
- ☐ Penicillin
- ☐ Codeine
- ☐ Acrylic
- ☐ Latex
- ☐ Metal
- ☐ Local Anesthetics
- ☐ Sulfa Drugs
- ☐ OTHER _____

Women: Are you…

- ☐ Pregnant
- ☐ Trying to get pregnant
- ☐ Nursing
- ☐ Taking oral contraceptives

1. Are you taking blood thinner (Coumadin)? _____
2. Are you presently taking medication for soft bone (Osteoporosis) (Fosamax)? _____
3. Smoke/ Chew or use any form of Tobacco? _____

SIGNATURE _____ DATE _____

Parent or Guardian if patient is a minor

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Name: _____ Date: _____

Drugs & Medications – I understand that antibiotics and other medications can cause allergic reactions causing redness and swelling of tissue, pain, itching, and/ or anaphylactic shock (severe allergic reaction). Analgesics may cause loss of feeling in my teeth, lips, tongue, and surrounding tissue (parasthesia) that can last for an indefinite period of time (days or months).

Initials_____

Changes in treatment plan – I understand that during the treatment it may be necessary to change or add procedures because of the conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give permission to the Dentist to make any/ all changes and additions as necessary.

Initials_____

Removal of teeth – Alternatives to removal have been explained to me (root canal therapy, crowns, periodontal surgery, etc.) and I authorize the Dentist to remove and any other necessary for reasons in paragraph #3. I understand removing the teeth does not always remove all the infection. If present, it may be necessary to have further treatment. I understand the risks involved in having teeth removed. Some of which are pain, swelling, spread of infection, dry socket, fractured jaw, loss of feeling in my teeth, lips, tongue, and surrounding tissue (parasthesia) can last for an indefinite period of time (days or months). I understand that I may need further treatment by a specialist or even hospitalization, if complications arise during or following treatment, the cost of which is my responsibility.

Initials_____

Crowns, bridges, & inlays – I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary restorations, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realize the final opportunity to make changes in my new crown, bridge, inlay, onlay, or veneer (including shape, fit, size, and color), will be before cementation.

Initials_____

Dentures (Complete or Partial) – I realize that full or partial dentures are artificial, constructed of plastic, metal, and / or porcelain. The problems of wearing appliances have been explained to me including looseness, soreness, and possible breakage. I realize the final opportunity to make changes in my new dentures (including shape, fit, size, placement and color) will be the “teeth in wax” try-in visit. I understand that most dentures require relining approximately three to twelve months after initial placement. The cost of this procedure is not included in the initial denture fee.

Initials_____

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Endodontic treatment (Root Canal) – I realize there is no guarantee that root canal treatment will save my tooth, and that complications can occur from the treatment, and that occasionally metal objects are cemented in the tooth or extended through the root which does not necessarily affect the success of the treatment. I understand that occasionally additional procedures may be necessary following root canal treatment.

Initials_____

Periodontal loss (Tissue & Bone) – I understand that I have a serious condition, causing gum and bone inflammation or loss and that it can lead to the loss of my teeth. Alternative treatment plans have been explained to me, including gum surgery, replacement and / or extractions. I understand that undertaking any dental procedures may have future adverse effect on my periodontal condition.

Initials_____

Implants – They are permanent alternative to bridges, partials or dentures. This process involves the participation of an oral surgeon. Fees for his/her services are separate from our service fees. This process involves several steps and could last from 2-6 months before complete (depending on healing time needed). As with crowns, colors may not match perfectly with natural teeth.

Initials_____

Sedative Fillings – Sedative fillings are temporarily. They are placed if near caries exposure of the nerve is suspected. If tooth becomes symptomatic after 4-6 weeks, it's likely the tooth will need a root canal or it may need to be extracted. The tooth is asymptomatic after 4-6 weeks, than the root has not been exposed. The sedative filling allows the tooth to lay down reparative dentin and will be enable the Doctor to remove the decay and restore the tooth.

Initials_____

I understand that dentistry is not an exact science and that therefore reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorized. I understand that each Dentist is an individual practitioner and is individually responsible for the dental care rendered to me. I also understand that no other Dentist other than Dr. Alsamaan is responsible for my dental treatment.

Signature _____ Date _____

Doctor/ Signature _____