

# DENTAL REGISTRATION

## Patient Information

Patient Name (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (MI) \_\_\_\_\_  
SSN# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Sex: Male Female Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_  
Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone Contact: Home: (\_\_\_\_) \_\_\_\_\_ Cell: (\_\_\_\_) \_\_\_\_\_ Work: (\_\_\_\_) \_\_\_\_\_  
Email Address: \_\_\_\_\_  
Emergency Contact: (Name) \_\_\_\_\_ Relationship: \_\_\_\_\_  
(Home) \_\_\_\_\_ (Cell) \_\_\_\_\_  
Marital Status: ( ) Married ( ) Single ( ) Minor ( ) Separated ( ) Divorced ( ) Partnered  
Patient Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_  
If Student: School \_\_\_\_\_ Full Time ( ) Part Time ( )

## Dental Insurance Information

Responsible Party for this account: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
Subscriber Name: \_\_\_\_\_ Insurance Company Name: \_\_\_\_\_  
Group #: \_\_\_\_\_ Policy ID#: \_\_\_\_\_ SSN#: \_\_\_\_\_ DOB: \_\_\_\_\_  
Secondary Insurance Yes \_\_\_\_\_ No \_\_\_\_\_ Subscriber Name: \_\_\_\_\_  
Insurance Name: \_\_\_\_\_ Group#: \_\_\_\_\_ ID#: \_\_\_\_\_ DOB: \_\_\_\_\_

### Assignment of Benefits/ Release of Patient Information

I certify that I, and/or my dependent (s), have insurance coverage with the above noted insurance company and assign directly to **Dr. Stephen B. Alouf/ Alouf Aesthetic Dentistry** all insurance benefits paid by insurance, unless otherwise indicated. I authorize the use of my signature on all insurance submissions. The above noted dentist may use my healthcare information and may disclose such information to the above noted insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services. This consent will remain valid and in effect unless we are otherwise notified in writing.

\_\_\_\_\_  
Patient/Guardian Signature

\_\_\_\_\_  
Relationship to patient

\_\_\_\_\_  
Date

### DENTAL HISTORY

Reason for today's visit \_\_\_\_\_ Former Dentist \_\_\_\_\_

Date of last dental visit \_\_\_\_\_ Last dental x-rays \_\_\_\_\_

Please indicate if you have had any of the following:

Bad Breath _____	Chew on one side of mouth _____	Fingernail biting _____	Jaw pain/tiredness _____	Mouth pain _____
Bleeding gums _____	Cigarette, pipe, cigar, chew _____	Food collects in teeth _____	Lip/check biting _____	Orthodontics _____
Blisters lip/mouth _____	Jaw clicks or pops _____	Grinding of teeth _____	Loose teeth _____	Periodontal tx _____
Burning on tongue _____	Dry Mouth _____	Gums swollen/tender _____	Mouth breather _____	Ear pain _____
How often do you brush? _____	How often do you floss? _____	Sensitivity to Hot _____ Cold _____ Sweets _____	Upon Biting _____	

PLEASE TURN OVER TO COMPLETE YOUR HEALTH HISTORY

# Medical History

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Are you under a physician's care now?	___Y___N	Physician's Name: _____
Have you been hospitalized or had a major operation?	___Y___N	Explain: _____
Have you ever had a serious head/neck injury?	___Y___N	Explain: _____
Are you taking any medications, pills, or drugs?	___Y___N	List: _____
Are you on a special diet?	___Y___N	Explain: _____
Have you ever taken Phen-Fen or Redux	___Y___N	When: _____
Do you use or have used bisphosphonate drugs?	___Y___N	Circle One: Fosamax, Reclast, Boniva, Actonel, Aredia, Zometa, other
Do you use tobacco products?	___Y___N	Frequency: _____
Do you use alcohol?	___Y___N	Frequency? _____
Do you use controlled substances?	___Y___N	Type: _____ Frequency: _____
Do you take any medications for digestive problems?	___Y___N	Prescription _____ Over the counter _____

Women: Are you pregnant? \_\_\_Y\_\_\_N Trying to get pregnant? \_\_\_Y\_\_\_N Taking oral contraceptives? \_\_\_Y\_\_\_N Nursing? \_\_\_Y\_\_\_N

## Are you allergic to any of the following?

\_\_\_Aspirin \_\_\_Penicillin \_\_\_Codeine \_\_\_Acrylic \_\_\_Metal \_\_\_Latex \_\_\_Local Anesthetics \_\_\_Sulfa drugs

Other, please explain: \_\_\_\_\_

## Do you have, or have you had, any of the following?

AIDS/HIV Positive	___Y___N	Cortisone meds	___Y___N	Hemophilia	___Y___N	Renal Dialysis	___Y___N
Alzheimer's Disease	___Y___N	Diabetes	___Y___N	Hepatitis A	___Y___N	Rheumatic Fever	___Y___N
Anaphylaxis	___Y___N	Drug addiction	___Y___N	Hepatitis B or C	___Y___N	Rheumatism	___Y___N
Anemia	___Y___N	Easily winded	___Y___N	Herpes	___Y___N	Scarlet Fever	___Y___N
Angina	___Y___N	Emphysema	___Y___N	High Blood Pressure	___Y___N	Shingles	___Y___N
Arthritis/Gout	___Y___N	Epilepsy/Seizures	___Y___N	Hives/Rash	___Y___N	Sickle Cell	___Y___N
Artificial Heart Valve	___Y___N	Excessive bleeding	___Y___N	Hypoglycemia	___Y___N	Sinus trouble	___Y___N
Artificial Joint	___Y___N	Excessive thirst	___Y___N	Irregular heartbeat	___Y___N	Spina bifida	___Y___N
Asthma	___Y___N	Fainting/Dizziness	___Y___N	Kidney problems	___Y___N	Stomach disease	___Y___N
Blood disease	___Y___N	Frequent cough	___Y___N	Leukemia	___Y___N	Stroke	___Y___N
Blood transfusion	___Y___N	Frequent diarrhea	___Y___N	Liver Disease	___Y___N	Swelling of limbs	___Y___N
Breathing Problem	___Y___N	Frequent headache	___Y___N	Low Blood Pressure	___Y___N	Thyroid disease	___Y___N
Bruise Easily	___Y___N	Genital herpes	___Y___N	Lung disease	___Y___N	Tonsillitis	___Y___N
Cancer	___Y___N	Glaucoma	___Y___N	Mitral valve prolapse	___Y___N	Tuberculosis	___Y___N
Chemotherapy	___Y___N	Hay fever	___Y___N	Pain in Jaw joints	___Y___N	Tumors/Growths	___Y___N
Chest Pains	___Y___N	Heart attack	___Y___N	Parathyroid disease	___Y___N	Ulcers	___Y___N
Cold sores/fever blisters	___Y___N	Heart Murmur	___Y___N	Psychiatric care	___Y___N	Venereal Disease	___Y___N
Congenital heart disorder	___Y___N	Heart pacemaker	___Y___N	Radiation treatment	___Y___N	Yellow Jaundice	___Y___N
Convulsions	___Y___N	Heart Disease	___Y___N	Recent weight loss	___Y___N		

Have you had any serious illness not listed above? If yes, please explain: \_\_\_\_\_

## Alouf Aesthetic & Implant Dentistry

### Patient Consent for Services

If applicable, I understand that my insurance coverage is an arrangement between myself and the insurance company. I understand that Dr. Alouf is not a contracted provider with any insurance company. Unless prior arrangements are made, I understand that services provided are payable at the time of treatment and insurance will reimburse me directly. Dr. Alouf's office may assist in filing claims, but I am responsible for the payment of all charges. Claims are submitted as a courtesy for our patients and we allow 30 days for your insurance company to respond. After 30 days, your account becomes due and payable by you (the responsible party).

Our financial coordinator will review all proposed treatment fees, insurance coverage, and payment options before treatment is rendered. All treatment and fees will be explained to me before I sign a consent. I understand that fees quoted for dental treatment are only guaranteed for a period of six months and are subject to change after that period.

### Finance Charge

A finance charge will be imposed on any overdue balances on your account not in compliance with agreed payment arrangements. The FINANCE CHARGE will be computed at the rate of (2%) per month or an ANNUAL PERCENTAGE RATE OF twenty four (24%) percent. The finance charge is computed by applying the periodic rate (2%) to the "overdue balance" (over 30 days) of your account.

**Returned Checks:** There is a fee (30\$) for any check returned by the bank for non payment.

**Appointment Confirmation:** Should the need arise to reschedule or possibly even cancel a scheduled appointment, we respectfully require a **48** hour notice. Failure to show for an appointment or adequately provide us with appropriate notice will result in a **RECOVERY FEE OF \$75.00**. We understand that sometimes there are circumstances beyond your control which would result in a late cancelled or missed appointment. Recovery fees are applied on a case by case basis following careful review of your account/appointment history.

### Delinquent Accounts

In the event that your account becomes delinquent, Dr. Alouf may limit your appointments to a frequency to guard against regression of work done. However, no adjustments for further progress will be made until the account is brought current.

If the delinquent account is referred for legal action the undersigned is agreed that the venue for all legal action shall be in the City of Salem, Virginia. The undersigned further agrees to pay all attorney fees of 33 1/3 % of the unpaid balance and all other associated court and collection costs. Benefit of Homestead and statute of limitations is waived. Dr. Alouf reserves the right to dismiss any patient/family from the practice for non payment of their account. If we retain a patient after a delinquent account is brought current, that patient will be cash for service only.

**Consent to Release/Review Dental Information/Records:** All patients have the right to expect that all communications and records pertaining to their care should be treated as confidential. So that Dr. Alouf may make a thorough examination and diagnosis, I understand that you may need to obtain information from my medical doctor and/or prior dentist (s). Therefore, I grant you the right to obtain records and information from my medical doctors and prior dentists. I also give permission to share my health information with other healthcare professionals which would include the release of dental charts and records.

I have read the above conditions of treatment and payment and agree to their content. A copy of this consent will be provided to me upon signature.

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Signature of patient/ parent/guardian

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Date

## CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

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### Section A: Patient Giving Consent

Patient Name: \_\_\_\_\_

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

Telephone: \_\_\_\_\_

### Section B: To the Patient--- Please read the following statements carefully

**Purpose of Consent:** By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

**Notice of Privacy Practices:** You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions, at any time by contacting:

Contact Person: **Sheri Martin - HIPAA Administrator**

Telephone: **540-375-0095**

Address: **1616 Apperson Drive Salem VA 24153**

**Right to Revoke:** You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

I, \_\_\_\_\_, have had full opportunity to read and consider the contents of this consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Personal Representative: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

## DIGITAL PHOTO WAIVER AND CONSENT

I, \_\_\_\_\_ the undersigned, do hereby authorize and consent to the use of certain digital photographs and/or diagnostic x-rays of me taken by **Alouf Aesthetic Dentistry**. I hereby grant them permission to reproduce, publish, print, use and distribute copies of such photographs/x-rays either in an official medical publication or in lectures for educational purposes. I further grant permission for my digital photos and diagnostic x-rays to be used on **www.aloufaesthetics.com** (Practice website) for educational purposes.

**(No full face or identifying photos will be used without your expressed written consent.)**

Please note that digital photography taken during treatment is used by our laboratories for cosmetic purposes in the fabrication of crowns, bridges, partials, veneers, dentures, and ortho. These images will be retained as a part of your permanent dental record.

Please initial one of the following:

\_\_\_\_\_ I **do not consent** to the use of digital photos or xrays for use in dental education or publications. These records are strictly for use in my plan of care.

\_\_\_\_\_ I **do consent** to the use of digital photos (**full face**) or xrays for use in dental education and/or publications including Alouf Aesthetic Dentistry's website, [www.aloufaesthetics.com](http://www.aloufaesthetics.com).

\_\_\_\_\_ I **do consent** to the use of digital photos (**no full face**) or xrays for use in dental education and/or publications including Alouf Aesthetic Dentistry's website, [www.aloufaesthetics.com](http://www.aloufaesthetics.com).

### COMPLIMENTARY CONSULTATION CONSENT FOR DIAGNOSTIC RECORDS

I authorize and consent to diagnostic records, including but not limited to, *Panorex, Diagnostic Study Models, Digital Photos, and Single x-rays*, to be used exclusively for the purpose of diagnosing, treatment planning, and case development. I understand these records will remain the property of Alouf Aesthetic Dentistry. I will not be charged for these records during my Complimentary Consultation, however; should I decide to seek an alternate opinion with another provider there will be a **\$150.00 fee** for duplicating and preparing these records. I further understand I will be required to sign a release of records authorization upon request.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date



ALOUF AESTHETICS

Alouf Aesthetic & Implant Dentistry

Patient Name: \_\_\_\_\_

**Thank you for choosing our practice. We hope you discover our dental philosophy is different than anything you have experienced before, because we pride ourselves on being *DIFFERENT!* Your participation in this first visit is very important and we would like to have your response to some questions that will be discussed.**

Tell us what you think of the current health condition of your mouth:

\_\_\_\_\_

How healthy do you want your mouth to be?

- Don't really care     Average     The best it can be

Do you like your smile? \_\_\_\_\_

Tell us about any bad dental experiences: \_\_\_\_\_

\_\_\_\_\_

Why did you leave your last dental provider? \_\_\_\_\_

What do you want to change about your smile? \_\_\_\_\_

Has fear ever been an issue for you in dental care? \_\_\_\_\_

Is time a factor in achieving your dental treatment? \_\_\_\_\_

Is the cost of dentistry a factor in having dental treatment? \_\_\_\_\_

We design your optimal dental care based on three perspectives. What combination are you looking for?

- A general dentist     A cosmetic dentist     A functional dentist

What quality of dentistry do you expect us to recommend?

- Just patch it     Average     Optimal/the best

Do you have any special concerns you would like to share with us? \_\_\_\_\_

\_\_\_\_\_