Welcome to Our Practice - Please Tell Us About Yourself

Today's Date *

mm/dd/yyyy

First Name *

Middle Initial

Last Name *

Preferred Name

Date of Birth *

*

- [ ] Male
- [ ] Female

*

- [ ] I have NOT scheduled an appointment yet.
- [ ] I have already scheduled an appointment, for the date of:

If under 18, person responsible for the account:

Social Security Number

Address *

City *

State *

Zip Code *

Home Phone

Work Phone

Cell Phone

Email Address

Employer

Occupation

Marital Status

- [ ] Single
- [ ] Married
- [ ] Divorced
- [ ] Widowed
- [ ] Domestic Partner

Preference for Appointment Confirmation, Check Any That Apply

- [ ] Phone
- [ ] E-Mail
- [ ] Text Message

If texting, the name of service provider

How did you hear about us? *

Insurance Information

Subscriber Name

Relationship to Patient

Employer

Subscriber Date of Birth

Insurance Company Name

Insurance Company Phone Number

Insurance ID Number

Group Number

Social Security Number

Secondary Insurance Information

Subscriber Name

Relationship to Patient

Employer

Subscriber Date of Birth

Insurance Company Name

Insurance Company Phone Number

Insurance ID Number

Group Number

Social Security Number

Medical History

Do you have a personal physician?

Date of last visit

☐ Yes ☐ No

Current Physician's Name

Physician's Phone Number

Are you currently under care of a physician?

☐ Yes ☐ No

If yes please explain

0/255 characters

Have you had any surgical procedures?

☐ Yes ☐ No

If yes please explain

0/255 characters

Have you had an adverse reaction to any medication or substance?

☐ Yes ☐ No

If yes please explain

0/255 characters

Are you taking any medications?

☐ Yes ☐ No

If yes please detail

0/255 characters

Please check any conditions that apply

- [ ] Abnormal Bleeding
- [ ] Alcohol Abuse
- [ ] Allergies
- [ ] Anemia
- [ ] Angina Pectoris
- [ ] Arthritis
- [ ] Artificial Heart Valve
- [ ] Artificial Joints
- [ ] Asthma
- [ ] Blood Transfusion
- [ ] Cancer
- [ ] Chemotherapy
- [ ] Cold Sores
- [ ] Colitis
- [ ] Congenital Heart Defect
- [ ] Cortisone Medicine
- [ ] Diabetes
- [ ] Difficulty Breathing
- [ ] Drug Abuse
- [ ] Eating Disorder
- [ ] Emphysema
- [ ] Epilepsy
- [ ] Facial Surgery
- [ ] Fainting Spells
- [ ] Fever Blisters
- [ ] Frequent Headaches
- [ ] Glaucoma
- [ ] HIV + AIDS
- [ ] Heart Attack
- [ ] Heart Murmur
- [ ] Heart Surgery
- [ ] Hemophilia
- [ ] Hepatitis A
- [ ] Hepatitis B
- [ ] Hepatitis C
- [ ] High Blood Pressure
- [ ] Implant (any type)
- [ ] Jaundice
- [ ] Joint Replacement
- [ ] Kidney Problems
- [ ] Liver Disease
- [ ] Low Blood Pressure
- [ ] Mitral Valve Prolapse
- [ ] Pacemaker
- [ ] Psychiatric Problems
- [ ] Radiation Therapy
- [ ] Rheumatic Fever
- [ ] Seizures
- [ ] STD
- [ ] Shingles
- [ ] Sickle Cell Disease
- [ ] Sinus Problems
- [ ] Sleep Apnea
- [ ] Stroke
- [ ] Transplant (any type)
- [ ] Thyroid Problems
- [ ] Tuberculosis
- [ ] Tumors
- [ ] Ulcers
- [ ] Venereal Disease

Do you have or have you had any disease, condition or problem not listed?

- [ ] Yes
- [ ] No

If yes please explain

0/255 characters

If Female, are you?

- [ ] On Birth Control
- [ ] Nursing
- [ ] Pregnant

Name of person to contact in case of an emergency

Emergency contact phone number

Dental History

How may we help you today?

Your current dental health is?

☐ Good ☐ Fair ☐ Poor

When was your last dental visit?

When was your last dental cleaning?

Do you have any current x-rays from another office? If answering yes to any below please have x-rays emailed to drallen@myomahadentist.com before day of appointment.

☐ Yes Bitewings less than 1 year old. ☐ Yes Panoramic less than 3 years old.

☐ No

Have you had any difficulty or unfavorable experiences with previous dental work?

☐ Yes ☐ No

If yes, please explain

Why did you leave your previous dentist?

0/255 characters

How can we accommodate you better during your visit?

Are you currently in pain?

☐ Yes ☐ No

Do you require antibiotics before treatment?

☐ Yes ☐ No

How often do you brush your teeth?

How often do you floss?

Do you have problems with bad breath?
☐ Yes ☐ No

Do you have problems with bleeding gums?
☐ Yes ☐ No

Do you use any forms of tobacco?
☐ Yes ☐ No

Have you ever had gum treatment?
☐ Yes ☐ No

Please check any of the services you would like to further discuss with Dr. Allen during your visit.

☐ Deep Gum Cleaning	☐ Sealants	☐ Tooth Colored Fillings
☐ Porcelain Crowns	☐ Veneers	☐ Bonding
☐ Bridges & Partials	☐ Dentures	☐ Implants
☐ Inlays/Onlays	☐ Root Canal Therapy	☐ Extractions
☐ Gum Contouring	☐ Teeth Grinding/TMJ	☐ Mouth Guards
☐ "Bite" Adjustments	☐ Invisalign (clear braces)	☐ Zoom Teeth Whitening
☐ Nitrous Oxide (laughing gas)	☐ "All Natural" Dentistry	☐ Mercury Fillings Removal
☐ Saliva Testing	☐ Biocompatibility Testing	☐ Airway/Breathing Issues

Have you ever had?

☐ Orthodontic treatment (braces)	☐ Oral Surgery	☐ A mouth guard
☐ Your "bite" adjusted	☐ An injury to the mouth or head	

Do You?

☐ Clench or grind your teeth while asleep	☐ Snore or suffer from sleep apnea
☐ Mouth breath while awake or asleep	☐ Bite your lips or cheeks regularly
☐ Hold foreign objects with your teeth (pencils, pipe, pins, nails, fingernails)	☐ Have tired jaws, especially in the morning

Have you ever experienced?

☐ Clicking or popping of the jaw	☐ Pain (joint, ear, side of face)
☐ Headaches, neckaches, or shoulderaches	☐ Sore muscles (neck, shoulders)
☐ History of trauma to your jaw	☐ Difficulty opening or closing the mouth
☐ Difficulty chewing on the either side of mouth	

Do you like your smile?
☐ Yes ☐ No

Are you happy with the color of your teeth?
☐ Yes ☐ No

If you could change anything about your smile and teeth, what would it be? (If you had a magic wand)

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information. We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

Treatment means provided, coordination, or managing health care and related services by one or more health care provider. An example of this would bee teeth cleaning services. Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for the payment. Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information. We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be if interest to you. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer.

The right to request restrictions on certain uses and disclosures of protected health information, included those related to disclosures to family members, other relatives, close personal friends or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction we must abide by it unless you agree in writing to remove it.
The right to reasonable requests to receive confidential communications of protected health information from us by alternative means at alternative locations.
The right to inspect and copy your protected health information.
The right to amend your protected health information.
The right to receive an accounting of disclosures of protected health information.
The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of you protected health information and to provide you with notice of your legal duties and privacy practices with respect to protected health information.

The notice is effective as of April 14, 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information.

For more information about HIPAA or to file a complaint:
The U.S. Department of Health & Human Services
Office of Civil Rights 200 Independence Avenue, S.W.
Washington, D.C. 20201
Toll Free: 1-8777-696-6775

Notice of Privacy Practices Acknowledgement
I have read and understand the Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that I can receive a paper copy of the Notice of Privacy Practices upon request. *

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Medical and Dental History Acknowledgement

I understand that the information in the Medical History and Dental History I have given is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence, and that you have my permission to ask the respective health care provider or agency for further information if needed. It is my responsibility to inform this office of any changes in my health or medications. *

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Consent for Treatment

I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of my dental needs. Upon such diagnosis we will provide a treatment plan specific to your needs and wants of the individual. I authorize the doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

Regarding Insurance

If you have dental insurance we do require your co-pay and deductible to be paid in full at the time of visit. The balance is your responsibility whether your insurance company pays for your treatment of not. We will gladly process your claims provided that you give us accurate, up to date insurance information. It is your responsibility to inform us of any changes in your insurance coverage. Your insurance policy is a contract between you and your insurance company. We are not a party to the contract. Please be aware that although we will call and verify your coverage, some and perhaps all, of the services provided may be non-covered or not considered reasonable/necessary under that policy your employer has selected. It is the insurance company that makes the final determination of your eligibility and payment. You agree to pay any portion of the charges not covered by insurance.

Financial Policy

All monies are due in full prior to or at the time services are rendered. We accept cash, check, credit card (this includes HSA's and Flex Accounts) and Care Credit. Though we do not anticipate the following circumstances we must, by law, make all patients aware of the following:

Finance Charge: A finance charge will be imposed on each item of your account, which has not been paid within sixty (60) days. The finance charge will computed at the rate of 1.5% per month. Past Due Accounts: If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all the collection fees that are incurred. If we have to refer collection of your account to a lawyer, you agree to pay all lawyers' fee which we incur plus all court cost. In case of suit, you agree the venue shall be in Omaha, NE and Douglas County.

I have read and understand the Consent for Treatment, Regarding Insurance and Financial Policy. *

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