CHARLES M. ALLEN, D.D.S.

6200 SARATOGA, SUITE B-1 * CORPUS CHRISTI, TEXAS 78414* 361-992-8900

PLEASE COMPLETE AND RETURN TO THE RECEPTIONIST.

NAME: Last	First	Middle			CHT.NO.
ADDRESS: Street or P.O. Box #	City	State	Zip Code		PHONE NUMBERS: Home: Work:
AGE-Yrs.	BIRTHDATE: Mo. / Day / Years	BIRTHPLACE	( ) Married ( ) Unmarried ( ) Separated		SOCIAL SECURITY NO.
OCCUPATION	EMPLOYER		HOW LONG EMPLOYED		ADDRESS & PHONE NO.
PERSON RESPONSIBLE FOR BILL	AGE	ADDRESS			RELATIONSHIP
OCCUPATION	EMPLOYER		HOW LONG EMPLOYED		ADDRESS & PHONE NO.
EMAIL ADDRESS					

GETTING TO KNOW YOU

1. Whom may we thank for referring you? _____

2. Why did you select our office? _____

3. Is another member of your family or relative a patient at our office? _____

4. Person to contact for emergency _____ Phone _____

INSURANCE INFORMATION

INSURED PERSON'S FULL NAME _____

SOCIAL SECURITY NUMBER _____ RELATIONSHIP TO PATIENT _____ ( ) WORK PHONE _____

INSURANCE COMPANY NAME _____ GROUP NUMBER _____ POLICY HOLDER'S BIRTHDATE _____

EMPLOYER NAME _____ FULL ADDRESS OF EMPLOYER _____

PAYMENT ALTERNATIVES

1. Cash and personal checks are accepted as your treatments are provided.
2. If you have dental insurance, we want you to receive the full benefit of it. Our office staff can assist you in completing your insurance forms and verifying the coverage that your particular program provides. We accept consignment of your insurance payment. This means that you are responsible for your deductible and the portion that insurance does not cover. Remember, however, THAT YOU ARE RESPONSIBLE FOR THE ENTIRE BALANCE IN THE INSURANCE DOES NOT HONOR THEIR COMMITMENT TO YOU AND TO US. _____ Signature
3. MasterCard, Visa, American Express, Discover
4. For those of you needing an extended payment program, our office offer Care Credit which, when you are accepted, will allow extended small monthly payments for the treatment received. This is a health care credit card.

FOR ALL PATIENTS

I hereby authorize the doctor to perform any and all forms of treatment, medication, and therapy, that may be indicated in connection with my dental care, or of the patient above, and further authorize and consent that the doctor chooses and employs such assistance as he deems fit. I also understand that previous to treatment, a full explanation of the procedure(s) involved will be given by the doctor and/or his staff. I agree to pay for all services rendered by this office.

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY _____ RELATIONSHIP _____ DATE _____

OVER For Medical History.

MEDICAL HISTORY

1. Are you having pain or discomfort at this time? ..... YES NO
2. Do you feel very nervous about having dental treatment? ..... YES NO
3. Have you ever had a bad experience in the dental office? ..... YES NO
4. Are you pleased with your present dental work? ..... YES NO
5. Have you been a patient in the hospital during the past two years? ..... YES NO
6. Have you been under the care of a medical doctor during the past two years? ..... YES NO
7. Have you ever had any excessive bleeding requiring special treatment? ..... YES NO
8. Are you allergic to (i.e., itching, rash, swelling of hands, feet or eyes) or made sick by penicillin, aspirin, codeine, or any drugs or medications? ..... YES NO
   If yes, please list. _____
9. Circle any of the following medical conditions that have affected you.

Heart Disease or Attack	Tuberculosis (TB)	Hepatitis B (serum)	Bruise Easily
Angina Pectoris	Asthma	Hepatitis C	
High Blood Pressure	Allergies or Hives	Liver Disease	
Rheumatic Fever	Diabetes	Blood Transfusion	
Congenital Heart Lesions	X-Ray or cobalt Treatment	Drug Addiction	
Artificial Heart Valve	Chemotherapy (Cancer, Leukemia)	Hemophilia	
Heart Pacemaker	Arthritis	Cold Sores	
Heart Surgery	Cortisone Medicine	Epilepsy or Seizures	
Stroke	Pain in Jaw Joints	Fainting or Dizzy Spells	
Kidney Trouble	AIDS (HIV Positive)	Nervousness	
Emphysema	Hepatitis A (infectious)	Psychiatric Treatment	

10. Do you have any of the following – artificial joints, Heart Murmur, Mitro Valve Prolapse? ..... YES NO
11. List any medical problem not mentioned above _____
12. Do you use or have you ever used recreational drugs, such as marijuana or cocaine? ..... YES NO
13. Have you ever been treated for substance abuse? ..... YES NO
14. Do you smoke? ..... YES NO
15. Do you have shortness of breath when sleeping, walking, or performing physical exertion of any kind? ..... YES NO
16. Do your ankles swell during the day? ..... YES NO
17. Do you use more than 2 pillows to sleep? ..... YES NO
18. Have you lost or gained more than 10 pounds in the last year? ..... YES NO
19. Are you on a special diet? ..... YES NO
20. Has your medical doctor ever said you have a cancer or tumor? ..... YES NO
21. WOMEN: Are you pregnant now? ..... YES NO
    Are you practicing birth control? (antibiotics reduce effectiveness) ..... YES NO
    Do you anticipate becoming pregnant? ..... YES NO
22. Have you ever taken bisphosphonates (chemotherapy, Fossamax, or Actone)? ..... YES NO
23. Are you taking any blood thinners? (cumadin, aspirin) other _____? ..... YES NO

Date of last dental exam. _____ Date of last physical exam. _____ Name of physician. _____

List all medications you are currently taking. _____

_____

List any current medical problems. _____

_____