ALANI
DENTAL

APPOINTMENT CANCELLATION POLICY

When a patient makes a dental appointment it is their responsibility to keep the appointment. If you need to change the appointment, we require two full business days to make changes without accruing an appointment change fee of $50 per hour.

After two no shows or two last minute cancellations, the doctor may choose to dismiss the patient from practice.

I understand and agree that I am responsible for keeping my dental appointments

____

PATIENT SIGNATURE

____

DATE

CONSENT TO DENTAL PHOTOGRAPHY

I authorize:

Dr. Mustafa Alani DDS and authorized members of the Alani Dental Care staff to take photographs and/or videos of my face, mouth, teeth, and jaws, before and after treatment.
I consent to allow the photographs to be used for the following professional purposes:

- Dental Records
- Dental Research
- Dental Education, for myself and others, including but not limited to training purposes, lectures, presentations, etc.
- Marketing material and advertisements, including limited use on social media, websites, printed materials, and in-office demonstrations

I further understand that if the photographs and/or videos are used, my name and other identifying information will be kept confidential.

I do not expect compensation, financial or otherwise, for the use of my photographs and/or videos.

I understand that the practice cannot condition the treatment I do or do not receive based on whether or not I sign this authorization.

I understand that information disclosed pursuant to this authorization may be subject to redisclosure and may no longer be protected by HIPAA privacy regulations.

____

PATIENT SIGNATURE

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____

PATIENT SIGNATURE

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DATE

Alani Dental Fleming Island
1845 W East Pkwy
Unit #3
Fleming Island, FL 32003
Ph # : 904-375-1990

Patient Personal Information

Title		Preferred Name	Birth Date		Age
Last, First			Marital Status		Sex
Address			Home #		Work #
			Cell #		Drive Lic
City, State, Zip			Emergency Contact		Emergency Phone #
Email			Student		SSN
Health Care Guardian Name			School Name		
Health Care Guardian Phone #			Referral Type		

Person responsible/guarantor for paying bills

Title		Preferred Name	Birth Date		Age
Last, First			Marital Status		Sex
Address			Home #		Work #
			Cell #		Drive Lic
City, State, Zip			SSN		
Email					

Do you have Primary Dental Insurance? __ Yes __ No			Do you have Secondary Dental Insurance? __ Yes __ No		
Group No/Name			Group No/Name		
Insurance Name			Insurance Name		
Phone #			Phone #		
Employer Name			Employer Name		
Subscriber Last, First			Subscriber Last, First		
Subscriber Address			Subscriber Address		
City, State, Zip			City, State, Zip		
Relationship to Patient		Birth Date	Relationship to Patient		Birth Date
Subscriber ID			Subscriber ID		

Patient Medical Information

Allergic To

- ☐ Y ☐ N No Known Allergies
- ☐ Y ☐ N Aspirin
- ☐ Y ☐ N Barbiturates / Sleeping Pills
- ☐ Y ☐ N Codeine
- ☐ Y ☐ N Erythromycin
- ☐ Y ☐ N Iodine
- ☐ Y ☐ N Latex Rubber
- ☐ Y ☐ N Local Anesthetics
- ☐ Y ☐ N Metals
- ☐ Y ☐ N No Epinephrine
- ☐ Y ☐ N Penicillin
- ☐ Y ☐ N Prior Hepatitis
- ☐ Y ☐ N Sulfa Drugs
- ☐ Y ☐ N Other Narcotics

Check, if applicable

- ☐ Y ☐ N Ankles Swell
- ☐ Y ☐ N Anorexia
- ☐ Y ☐ N Arteriosclerosis
- ☐ Y ☐ N Arthritis
- ☐ Y ☐ N Asthma
- ☐ Y ☐ N Autoimmune Disease
- ☐ Y ☐ N Bladder Trouble
- ☐ Y ☐ N Blood Clotting Problems
- ☐ Y ☐ N Blood Transfusion
- ☐ Y ☐ N Bulimia
- ☐ Y ☐ N Bronchitis
- ☐ Y ☐ N Cancer / Tumor or Growth
- ☐ Y ☐ N Cardiac Pacemaker
- ☐ Y ☐ N Cardiovascular Disease
- ☐ Y ☐ N Chemotherapy
- ☐ Y ☐ N Environmental Allergies
- ☐ Y ☐ N Epilepsy
- ☐ Y ☐ N Fainting Spells
- ☐ Y ☐ N Fever Blisters
- ☐ Y ☐ N Frequent Headaches
- ☐ Y ☐ N Frequently Dry Mouth / Sjogren
- ☐ Y ☐ N Gag Reflex
- ☐ Y ☐ N Gall Bladder Trouble
- ☐ Y ☐ N Hay Fever
- ☐ Y ☐ N Heart Attack
- ☐ Y ☐ N Heart Disease
- ☐ Y ☐ N Heart Murmur
- ☐ Y ☐ N Hepatitis
- ☐ Y ☐ N Herpes
- ☐ Y ☐ N High Blood Pressure
- ☐ Y ☐ N Hives
- ☐ Y ☐ N Mental Health Problems
- ☐ Y ☐ N Mitral Valve Prolapse
- ☐ Y ☐ N Pacemaker
- ☐ Y ☐ N Persistent Diarrhea
- ☐ Y ☐ N Premedicate
- ☐ Y ☐ N Radiation Treatment
- ☐ Y ☐ N Rheumatic Fever
- ☐ Y ☐ N Rheumatic Heart Disease
- ☐ Y ☐ N Rheumatoid Arthritis
- ☐ Y ☐ N Seizures
- ☐ Y ☐ N Sexually Transmitted Disease
- ☐ Y ☐ N Shortness of Breath
- ☐ Y ☐ N Skin Rash
- ☐ Y ☐ N Sinus Trouble
- ☐ Y ☐ N Stomach Ulcers

- ☐ Y ☐ N No Change Since Last Recorded
- ☐ Y ☐ N No Known Concerns or Issues
- ☐ Y ☐ N Abnormal Bleeding
- ☐ Y ☐ N AIDS/HIV Infection
- ☐ Y ☐ N Alcohol/Drug Abuse
- ☐ Y ☐ N Angina
- ☐ Y ☐ N Anemia
- ☐ Y ☐ N Chest Pain Upon Exertion
- ☐ Y ☐ N Color Blindness
- ☐ Y ☐ N Congenital Heart Defect
- ☐ Y ☐ N Contact Lenses
- ☐ Y ☐ N Congestive Heart Failure
- ☐ Y ☐ N Damaged Heart Valve
- ☐ Y ☐ N Diabetes
- ☐ Y ☐ N Emphysema
- ☐ Y ☐ N Jaundice
- ☐ Y ☐ N Joint Replacement
- ☐ Y ☐ N Kidney
- ☐ Y ☐ N Leukemia
- ☐ Y ☐ N Liver Disease
- ☐ Y ☐ N Low Blood Pressure
- ☐ Y ☐ N Lupus
- ☐ Y ☐ N Stroke
- ☐ Y ☐ N Thyroid Problems
- ☐ Y ☐ N Tuberculosis
- ☐ Y ☐ N Unusual Weight Loss
- ☐ Y ☐ N Urinate Frequently

Other

- ☐ Y ☐ N See Scanned Documents: Pt Note
- ☐ Y ☐ N Premed

Additional Comments

Dental Questionnaire

Dental Questionnaire

Name of previous Dentist ________________

Phone ________________

Date of your last cleaning ________________

Last exam date ________________

Date of your last full series x-rays ________________

Date of last cavity detection (bitewing) x-rays ________________

Do your gums bleed while brushing or flossing ? ________________

Are your teeth sensitive to hot, cold or sweets ? ________________

Do you get frequent fever blisters, mouth ulcers, or sores on your lips or in your mouth ? ________________

Have you ever had burning of the tongue or cracking of the corners of your mouth ? ________________

Do you chew/smoke tobacco in any form ? ________________

Have you had any head, neck or jaw injuries ? ________________

Do you notice popping, clicking or soreness of the jaws or points just in front of the ears ? ________________

Do you clench or grind your teeth ? ________________

Have you ever had orthodontic treatment ? ________________

If Yes, date of placement ________________

Do you wear dentures or partials ? ________________

If Yes, date of placement of dentures ? ________________

Are you happy with your dentures ? ________________

Are you having any specific problems with your teeth, gums, or mouth at this time ? ________________

Are you happy with your smile ? ________________

Do you have problems with teeth/fillings breaking ? ________________

Do you regularly use dental floss ? ________________

Do you have, or have you ever been told, that you have Pyorrhea (Periodontal Disease) ? ________________

Do you have difficulty in opening your mouth widely ? ____________________

Do you have an unpleasant taste or odor in your teeth/mouth ? ____________________

Does food catch between your teeth ? ____________________

Do you want to learn to control your dental disease and retain your teeth ? ____________________

Additional Comments

Any Disease, Condition or Problem not Listed ? Please list ____________________

Medical Questionnaire

Are you currently under care of a Physician ? ____________________

If Yes, what is the condition being treated ? ____________________

Have you had any serious illness, operation or been hospitalized within the past 5 years ? ____________________

If Yes, what illness or problem ? ____________________

Are you currently taking any medication ? ____________________

If Yes, what ? ____________________

Have you taken bisphosphonates (Fosamax, Boniva, Zometa, Actonel, Didronel, Aredia, Skelid, Reclast) ____________________

Do you smoke ? ____________________

Have you ever taken the diet control drug Fen-Phen ? ____________________

Do you use alcoholic beverages ? ____________________

Women Only

Are you pregnant? ____________________

If Yes, what is your due date ? ____________________

Are you currently nursing ? ____________________

Are you on hormone replacement therapy ? ____________________

Are you on birth control pills / fertility drugs ? ____________________

Additional Comments

Any Disease, Condition or Problem not Listed ? Please list ____________________

By signing below, I certify that all of the above information is true to the best of my knowledge.

____________________ ____________________

Patient/Guardian Signature **Date**

____________________ ____________________

Dentist Signature **Date**