Personal Information

Name Last	First	Middle		
Address Street or P.O. Box #	City	State	Zip Code	Phone No. Home: Work:
Pager # :	Cell Phone:	Email Address:		
Age: Yrs.	Birth Date Mo. Day Year	(Male_____ Female_____)		( ) Married ( ) Unmarried ( ) Separated
Social Security No. (if child, parents)		Drivers's License No.		
Occupation	Employer	How long employed?		Address & Phone No.
Person responsible for bill	Age	Address	Relationship	Social Security No. / Driver's License No.
Occupation	Employer	How long employed?		
Employer Address & Phone No.				

Insurance Information

Insured Person's Full Name _____ Date of Birth _____

Social Security Number _____ Relationship to Patient _____ Work Phone _____

Insurance Company Name _____ Group or Union Name _____ Group or Local Number _____

Employer's name _____ Full Address of Employer _____

Getting to Know You

1. Why did you select our practice?

2. Whom may we thank for referring you?

3. Is another member of your family or relative a patient in our practice?

4. Person to contact for emergency:
   Phone: _____

5. When was your last dental visit? _____

6. When was the last time you had complete dental radiographs taken?
   Name & Address of Last Dentist: _____

7. Have you ever had any teeth removed? _____
   How long have these teeth been missing? _____
   Have these teeth been replaced? _____
   How? ☐ Bridge ☐ Partial ☐ Denture ☐ Implants

Getting to Know You

Please check appropriate box:

☐ 1. As a special service to you, we offer a cash courtesy if you pay for entire treatment plan in full, in advance.

☐ 2. Cash and personal checks are accepted as your treatments are provided.

☐ 3. If you have dental insurance, we want you to receive the full benefit of it. Our office team can assist you in completing your insurance forms and verifying the coverage that your particular program provides. We accept assignment of your insurance payment; another service to you. This means that you are responsible for your deductible and the portion the insurance does not cover. Remember, however, that you are responsible for the account if the insurance company, for any reason, does not honor their commitment to you and to us.

☐ 4. Mastercard, Visa, Discover

☐ 5. For long term or extended payments, we offer a healthcare financing program, which when your are accepted, will allow extended small monthly payments for the treatment received.

FOR ALL PATIENTS

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

_____

Signature of Responsible party Relationship Date

MEDICAL HISTORY

1. Have you been under the care of a medical doctor during the past two years? ☐ Yes ☐ No
   If yes, for what reason? _____
   Please provide the name, address, and the telephone number of your physician.
   _____
2. Have you been a patient in the hospital during the past two years? ☐ Yes ☐ No
   If yes, for what reason? _____
3. Have you taken any medicine or drugs during the past two years? If yes, please list: _____ ☐ Yes ☐ No
   _____
4. Are you allergic to (i.e., itching, rash, swelling of hands, feet or eyes) or made sick by penicillin, latex, aspirin, codeine, or any drugs or medicines? If yes, please list: _____ ☐ Yes ☐ No
   _____
5. Have you ever had excessive bleeding requiring special treatment? ☐ Yes ☐ No
6. Do you use any tobacco products? ☐ Yes ☐ No
7. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, or shortness of breath, or because you are very tired? ☐ Yes ☐ No
8. Do your ankles swell during the day? ☐ Yes ☐ No
9. Have you lost or gained more than 10 pounds in the last year? ☐ Yes ☐ No
10. Do you use more than 2 pillows to sleep? ☐ Yes ☐ No
11. Do you ever wake up from sleep short of breath? ☐ Yes ☐ No
12. Are you on a special diet? ☐ Yes ☐ No
13. Check any of the following which apply in either past or present:

☐ Heart Valve Prolapse	☐ High Blood Pressure	☐ Cortisone Medication
☐ Heart Failure	☐ Anemia	☐ Arthritis
☐ Heart Disease or Attack	☐ Asthma	☐ Pain in Jaw Joints
☐ Family History of Cardiovascular Disease	☐ Emphysema	☐ X-Ray Cobalt Treatment
☐ Angina pectoris (chest pain)	☐ Shortness of Breath	☐ Cancer or Tumors
☐ Rheumatic Fever	☐ Hay Fever	☐ Chemotherapy (Cancer, Leukemia)
☐ Congenital Heart Lesions	☐ Allergies or Hives	☐ Thyroid Disease
☐ Scarlet Fever	☐ Fainting or Dizzy Spells	☐ Glaucoma
☐ Artificial Heart Valve	☐ Epilepsy or Seizures	☐ HIV Positive (AIDS)
☐ Heart Pacemaker	☐ Nervousness	☐ Venereal Disease
☐ Heart Surgery	☐ Psychiatric Treatment	☐ Cold Sores or Fever Blisters
☐ Artificial Joint of Any Type	☐ Any Form of Eating Disorder	☐ Genital Herpes
☐ Diet Medication: Name _____	☐ Recreational Drug Use	☐ Kidney Trouble
☐ Heart Murmur	☐ Drug Addiction/Alcoholism	☐ Diabetes
☐ Bruise Easily	☐ Tuberculosis (TB)	☐ Ulcers
☐ Blood Transfusion	☐ Any Form of Hepatitis	☐ Stroke
☐ Hemophilia	☐ Liver Disease	☐ Birth Control Medication
☐ Sickle Cell Disease	☐ Rheumatism	☐ Pregnant - Due Date _____

14. Do you have any disease, condition of problem not listed? If so, please list: _____ ☐ Yes ☐ No.
    _____
    _____

Date _____

Signature: _____

ACKNOWLEDGEMENT OF RECEIPT OF

NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign this Acknowledgement

I,_____, have received a copy of this office Notice of Privacy Practices.

_____

(Please Print Name)

_____ _____

(Signature) (Date)

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

____ Individual refused to sign
____ Communication barriers prohibited obtaining the acknowledgement
____An emergency situation prevented us from obtaining acknowledgement
____ Other (Please Specify)

_____

_____

_____

_____

CONSENT

The undersigned hereby authorizes doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the Doctor to make a thorough diagnosis of the patients, dental needs. I also, authorize the Doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment in connection with (name of patient) _____. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that doctor choose and employ such assistance as deemed fit to provide recommended treatment. Lastly, I understand that all responsibility for dental services provided in this office for myself or my dependents are mine, due and payable at the time services are rendered unless other arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that a 1-1/2% finance charge (18% APR) may be added to my account. By signing below, I understand and agree that in the event of default, I am legally liable for all costs of collection including collection fees, reasonable attorney fees, court costs, and all other costs related to the collection of this debt.

Patient_____Date_____
Parent or Responsible Party_____
Relationship to Patient_____
Witness_____Date_____

Authorization and Release

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to my child or me during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for service.

PLEASE NOTE: PREMIER DENTAL CENTER IS NOT RESPONSIBLE FOR KNOWING YOUR INSURANCE BENEFITS IN DETAIL. OUR ESTIMATES ARE STRICTLY ESTIMATES!

X_____
Patient signature and/or financially responsible party (parent/guardian if minor)

Dental History

In order to serve you in the best way possible, please share the following information:

Name and contact information of previous dentist:

Why did you leave your previous dentist?

Please share the following dates:

Last cleaning: __ /__

Last exam: __ / __

Last complete set of x-rays: __ /__

Last oral cancer screening: __ /__

Please check all that apply to you:

__ Tooth sensitivity to hot or cold

__ Pain or discomfort when chewing

__ Headaches, earaches, neck pain

__ Jaw joint pain

__ Teeth cracking or fillings breaking

__ Grinding or clinching teeth

__ Bleeding or swollen gums

__ Loose, tipped or shifting teeth

__ Bad breath or bad taste in your mouth

__ Fever blisters, mouth ulcers, or sores on lips or gums.

__ Difficulty opening mouth wide

__ Food getting caught in teeth

Have you had any of the following:

__ Dentures __ Partial dentures

__ Braces

__ Periodontal (gum) treatment

Do you chew/smoke tobacco in any form?

Yes No

How often do you brush your teeth?

Daily - Weekly - Monthly - Never

How often do you floss?

Daily - Weekly - Monthly - Never

Do you want to keep your natural teeth?

Yes No

If you could change your smile, you would:

__ Make teeth brighter

__ Make teeth straighter

__ Close spaces

__ Replace black, metal fillings with natural tooth-colored fillings.

__ Repair chipped teeth

__ Replace missing teeth

__ Replace old crowns that don't match

__ Have a smile "make over"

If you could whiten your teeth for an investment anyone could afford, would you be interested? Yes No

On a scale of 1 to 10 with 10 being the highest rating:

How important is your dental health to you?

1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

Where would you rate your current dental health?

1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

What is the most important thing to you about your future smile and dental health?

What is the most important thing to you about your dental visit today?