

Welcome

Welcome

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Welcome To Premier Dental

PATIENT INFORMATION

Date _____

Mr. Mrs. Ms. Dr. First Name _____ M.I. _____ Last Name _____ Nickname _____

Sex: Male Female Birth Date _____ Age _____ Soc. Sec. # _____ E-mail _____

Street _____ City _____ State _____ Zip _____

Home Tel. (_____) _____ Cell. (_____) _____ Have you ever been a patient of our practice? Yes No

Dentist _____ Medical Doctor _____ Referred By _____

Driver's Lic.# _____ Nearest relative not living with you _____ Tel. (_____) _____

Employer _____ Bus. Tel. (_____) _____ Personal Payment Type: Cash Check Credit Card

In case of emergency, please contact _____ Tel. (_____) _____ Relation _____

Who will be responsible for your account?

(If self, skip to next section)

Self Spouse Father Mother Other _____

Name _____ S.S.# _____ Birth Date _____ Age _____ Tel. (_____) _____

Street _____ City _____ State _____ Zip _____

Employer _____ Bus. Tel. (_____) _____

Spouse or other guarantor information (if different from above)

Name _____ Relation _____ S.S.# _____ Birth Date _____

Street _____ City _____ State _____ Zip _____

Tel. (_____) _____ Employer _____ Bus. Tel. (_____) _____

INSURANCE INFORMATION

Student: Full Time Part Time Not School Name/Address _____

Married Divorced Legally Separated Widow Single _____

Employed: Full Time Part Time Retired Not Do you belong to a PPO or HMO? Yes No

PRIMARY DENTAL INSURANCE COMPANY

Employer _____

Bus. Address _____

Bus. Tel. (_____) _____ Plan _____

Ins. Co. Name _____

Address _____

_____ Tel. (_____) _____

Group # _____ Group Name _____

Insured Party _____ Relation _____

Sex: M F Birth Date _____

Street _____

City, State, Zip _____

Tel. (_____) _____ S.S. # _____

I.D. # _____

SECONDARY DENTAL INSURANCE COMPANY

Employer _____

Bus. Address _____

Bus. Tel. (_____) _____ Plan _____

Ins. Co. Name _____

Address _____

_____ Tel. (_____) _____

Group # _____ Group Name _____

Insured Party _____ Relation _____

Sex: M F Birth Date _____

Street _____

City, State, Zip _____

Tel. (_____) _____ S.S. # _____

I.D. # _____

DENTAL INFORMATION

Reason for today's visit: _____ Are you in pain? Yes No, For How Long? _____

Please indicate any of the following problems by checking off the corresponding box:

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Discomfort, clicking, or popping in jaw | <input type="checkbox"/> Lost / broken filling(s) | <input type="checkbox"/> Stained teeth | <input type="checkbox"/> Difficulty closing jaw |
| <input type="checkbox"/> Red, swollen, or bleeding gums | <input type="checkbox"/> Teeth grinding / clenching | <input type="checkbox"/> Locking jaw | <input type="checkbox"/> Difficulty opening jaw |
| <input type="checkbox"/> A removable dental appliance | <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Bad breath | <input type="checkbox"/> Loose / shifting teeth |
| <input type="checkbox"/> Blisters / sores in or around the mouth | <input type="checkbox"/> Broken / chipped tooth | <input type="checkbox"/> Burning tongue / lips | <input type="checkbox"/> Food caught between teeth |
| <input type="checkbox"/> Prolonged bleeding from an injury / extraction | <input type="checkbox"/> Gum disease | <input type="checkbox"/> Toothache | <input type="checkbox"/> Swelling / lumps in mouth |
| <input type="checkbox"/> Recent infections or sore throat | <input type="checkbox"/> Other: _____ | | |

My teeth are sensitive to: Hot Cold _____

Sweets Biting _____

Last dental exam _____ Last dental x-rays _____ Times a day you brush? _____ Times a week you floss? _____

How would you rate your smile? (worst) 1 2 3 4 5 6 7 8 9 10 (best) Would you like whiter teeth? Yes No

What type of toothbrush bristles do you use? Soft Medium Hard

MEDICAL HISTORY

Are you in good health? Yes No Height _____ Weight _____ Are you under the care of a physician? Yes No

Have you had any illness, operation, or been hospitalized in the past five years? Yes No

Physician's name _____ Physician's phone (_____) _____

Do you have, or have you had, any of the following diseases, medical conditions, or procedures?

- | | | | |
|--|---|--|---|
| Y N
<input type="checkbox"/> <input type="checkbox"/> Abnormal bleeding
<input type="checkbox"/> <input type="checkbox"/> Alcohol abuse
<input type="checkbox"/> <input type="checkbox"/> Allergies
<input type="checkbox"/> <input type="checkbox"/> Anemia
<input type="checkbox"/> <input type="checkbox"/> Angina pectoris
<input type="checkbox"/> <input type="checkbox"/> Arthritis
<input type="checkbox"/> <input type="checkbox"/> Artificial bones
<input type="checkbox"/> <input type="checkbox"/> Artificial heart valve(s)
<input type="checkbox"/> <input type="checkbox"/> Asthma
<input type="checkbox"/> <input type="checkbox"/> Blood transfusion
<input type="checkbox"/> <input type="checkbox"/> Cancer / chemotherapy
<input type="checkbox"/> <input type="checkbox"/> Colitis
<input type="checkbox"/> <input type="checkbox"/> Congenital heart defect
<input type="checkbox"/> <input type="checkbox"/> Cosmetic surgery
<input type="checkbox"/> <input type="checkbox"/> Diabetes
<input type="checkbox"/> <input type="checkbox"/> Difficulty breathing
<input type="checkbox"/> <input type="checkbox"/> Drug abuse | Y N
<input type="checkbox"/> <input type="checkbox"/> Emphysema
<input type="checkbox"/> <input type="checkbox"/> Epilepsy
<input type="checkbox"/> <input type="checkbox"/> Fainting spells
<input type="checkbox"/> <input type="checkbox"/> Fever blisters
<input type="checkbox"/> <input type="checkbox"/> Glaucoma
<input type="checkbox"/> <input type="checkbox"/> Heart attack
<input type="checkbox"/> <input type="checkbox"/> Heart surgery
<input type="checkbox"/> <input type="checkbox"/> Hemophilia
<input type="checkbox"/> <input type="checkbox"/> Hepatitis A
<input type="checkbox"/> <input type="checkbox"/> Hepatitis B
<input type="checkbox"/> <input type="checkbox"/> High blood pressure
<input type="checkbox"/> <input type="checkbox"/> HIV + AIDS
<input type="checkbox"/> <input type="checkbox"/> Kidney problems
<input type="checkbox"/> <input type="checkbox"/> Liver disease
<input type="checkbox"/> <input type="checkbox"/> Mitral valve prolapse
<input type="checkbox"/> <input type="checkbox"/> Low blood pressure
<input type="checkbox"/> <input type="checkbox"/> Pace maker | Y N
<input type="checkbox"/> <input type="checkbox"/> Psychiatric problems
<input type="checkbox"/> <input type="checkbox"/> Radiation therapy
<input type="checkbox"/> <input type="checkbox"/> Rheumatic fever
<input type="checkbox"/> <input type="checkbox"/> Seizures
<input type="checkbox"/> <input type="checkbox"/> Shingles
<input type="checkbox"/> <input type="checkbox"/> Sinus problems
<input type="checkbox"/> <input type="checkbox"/> Stroke
<input type="checkbox"/> <input type="checkbox"/> Thyroid problems
<input type="checkbox"/> <input type="checkbox"/> Tuberculosis
<input type="checkbox"/> <input type="checkbox"/> Ulcers
<input type="checkbox"/> <input type="checkbox"/> Venereal disease
<input type="checkbox"/> <input type="checkbox"/> Yellow jaundice
<input type="checkbox"/> <input type="checkbox"/> Bruise easily
<input type="checkbox"/> <input type="checkbox"/> Osteoporosis
<input type="checkbox"/> <input type="checkbox"/> Do you smoke
<input type="checkbox"/> <input type="checkbox"/> Do you use chewing tobacco
<input type="checkbox"/> <input type="checkbox"/> Blood disorder | Y N
<input type="checkbox"/> <input type="checkbox"/> Are you on dialysis
<input type="checkbox"/> <input type="checkbox"/> Contact lenses
<input type="checkbox"/> <input type="checkbox"/> Heart murmur
<input type="checkbox"/> <input type="checkbox"/> Low blood sugar
<input type="checkbox"/> <input type="checkbox"/> Tumor or growth
<input type="checkbox"/> <input type="checkbox"/> Are you on a diet
<input type="checkbox"/> <input type="checkbox"/> Trouble climbing 1-2 flights of stairs
<input type="checkbox"/> <input type="checkbox"/> Snoring / sleep apnea
<input type="checkbox"/> <input type="checkbox"/> Chronic fatigue/ nights sweats
<input type="checkbox"/> <input type="checkbox"/> Swollen ankles
<input type="checkbox"/> <input type="checkbox"/> Gallbladder trouble
<input type="checkbox"/> <input type="checkbox"/> Bleeding tendency
<input type="checkbox"/> <input type="checkbox"/> Delay in healing
<input type="checkbox"/> <input type="checkbox"/> Malignant hypothermia
<input type="checkbox"/> <input type="checkbox"/> Damaged heart valves
<input type="checkbox"/> <input type="checkbox"/> Immune system problems
<input type="checkbox"/> <input type="checkbox"/> Contagious diseases |
|--|---|--|---|

MEDICATION AND ALLERGIES

Are you now taking or have you taken:

- | | | | |
|--|---|--|---|
| Y N
<input type="checkbox"/> <input type="checkbox"/> Nerve pills
<input type="checkbox"/> <input type="checkbox"/> Have you ever taken diet pills
<input type="checkbox"/> <input type="checkbox"/> Blood thinners
(Coumadin, Aspirin, Advil)
<input type="checkbox"/> <input type="checkbox"/> Any bone density medication
or Bisphosphonates (Aredia,
Zometa, Fosamax, Actonel) | Y N
<input type="checkbox"/> <input type="checkbox"/> Pain killers (including aspirin)
<input type="checkbox"/> <input type="checkbox"/> Tranquilizers | Y N
<input type="checkbox"/> <input type="checkbox"/> Muscle relaxers
<input type="checkbox"/> <input type="checkbox"/> Insulin | Y N
<input type="checkbox"/> <input type="checkbox"/> Stimulants
<input type="checkbox"/> <input type="checkbox"/> Antidepressants |
|--|---|--|---|
- Please list any other medication(s) you are taking (including natural, herbal, or homeopathic products):

Are you allergic to or had a reaction to:

- | | | | |
|---|---|---|--|
| Y N
<input type="checkbox"/> <input type="checkbox"/> Aspirin
<input type="checkbox"/> <input type="checkbox"/> Codeine
<input type="checkbox"/> <input type="checkbox"/> Dental anesthesia | Y N
<input type="checkbox"/> <input type="checkbox"/> Erythromycin
<input type="checkbox"/> <input type="checkbox"/> Jewelry | Y N
<input type="checkbox"/> <input type="checkbox"/> Latex
<input type="checkbox"/> <input type="checkbox"/> Metals | Y N
<input type="checkbox"/> <input type="checkbox"/> Penicillin
<input type="checkbox"/> <input type="checkbox"/> Tetracycline |
|---|---|---|--|
- Please list any other allergies other than drug allergies:

Please list any other medication or antibiotic you are allergic to:

1-4 below for women only: (women note: antibiotics (such as penicillin) may alter the effectiveness of birth control pills. consult your physician / gynecologist for assistance regarding additional methods of birth control.)

- 1) Are you taking birth control pills? Yes No 3) If yes, how many weeks along are you _____
- 2) Are you pregnant? Yes No 4) Are you nursing? Yes No

I certify that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my doctor, or any other member of his / her staff, responsible for any errors or omissions that I have made in the completion of this form.

Signature of patient: **X**
(Parent or Guardian if minor)

Reviewed by: **X**

Date: **X**

FEES AND PAYMENTS

We make every effort to keep down the cost of your care. You can help by paying upon completion of each visit. Other arrangements can be made with our office manager depending upon special circumstances. An estimate of the charge for any procedure or surgery you may require will be given to you upon request. If you have any dental and/or medical insurance we will be glad to fill out the proper forms, but please complete the identifying information on this form.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. **It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance company.** You will be responsible for all collection costs, attorneys fees, and court costs.

Signature of patient: (Parent or Guardian if minor) **X**

Date: **X**

This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to this doctor named of the benefits otherwise payable to me.

Signature of patient: (Parent or Guardian if minor) **X**

Date: **X**

I hereby acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice.

Signature of patient: (Parent or Guardian if minor) **X**

Date: **X**