Welcome to Premier Dental Center

Thank you for taking the time to come see us today. We would like to know you better.

The primary reason for my visit today is to discuss:

____

____

____

In addition to my primary purpose, I would appreciate hearing about these other procedures:

□ Teeth whitening and bleaching

□ Veneers and cosmetic dental treatments

□ Dental Implants

□ Snoring Reduction

□ Braces

□ Replacing silver fillings

□ Replace missing teeth

I selected this practice because:

□ A personal friend referred me ____

□ Convenient location and office hours

□ Knowledge that the doctor offers flexible payment terms

□ Newspaper or magazine Advertising

□ Google

□ Yellow page Advertising

□ Newsletter

□ Postcard

□ Other (please explain)

____

____

We are pleased to offer our patients an easy monthly payment program. Please indicate which payment options you may be interested in.

□ 5% cash discount, for amounts greater than $300. Full treatment cost must be paid in full with the insurance reimbursing the patient in full. We will provide a claim form for submission. Payment must be cash or check.

□ Interest free payment plan offered by one of our financing companies : 6 months or 12 months

□ Extended payment plan for 48 months

PREMIER DENTAL CENTER

Adult			
Name			
Spouse			
Address			
City	State	Zip	
Home #	Cell or Work #		
Birthday	Social Security #		
Email Address			
Married	Single	Divorced	Widowed

Child		
Name		
Address		
City	State	Zip
Home #		
Birthdate	Age	Grade
School		

Emergency Contact
Person to contact
Relationship
Phone #

Dental Insurance	
Primary Carrier	
Name of Insured	
Social Security #	Birthday
Employer	
Name of Insurance	
Group #	
Secondary Carrier	
Name of Insured	
Social Security #	Birthday
Employer	
Name of Insurance	
Group #	

Account Information
Person Financially Responsible For Account
Name
Relationship to patient
Employer
Driver's License #
Work #

ASSIGNMENT AND RELEASE

Be advised that insurancce is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. I understand that I am financially responsible for all charges whether or not paid by insurance. I understand that I am responsible to pay any deductibles and co pays. I hereby authorize the doctor to release all information necessary to secure payment from carrier. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature **Relationship** **Date**

Dental & Medical History

Name ______________________________ Physician Name ________________________________

Date of Birth ________________________ Date of last physical ____________________________

	Yes	No
Are you under any medical treatment now? If so explain: ______________________________________	☐	☐
Have you had any major operations? If so what? ____	☐	☐
Have you ever had a serious accident involving head injury? ___________________________________	☐	☐

Please check yes or no, if you have or had any of the following:

	Yes	No		Yes	No		Yes	No
AIDS or HIV	☐	☐	Glaucoma	☐	☐	Rheumatic Fever	☐	☐
Arthritis/Rheumatism	☐	☐	Headaches	☐	☐	Shortness of breath	☐	☐
Artificial heart valve	☐	☐	Heart Murmur	☐	☐	Sinus Trouble	☐	☐
Artificial Joints	☐	☐	Heart Problems	☐	☐	Special Diet	☐	☐
Asthma	☐	☐	Hepatitis	☐	☐	Stomach/Intestinal Disease	☐	☐
Blood Disease	☐	☐	Type ______________			Thyroid Disease	☐	☐
Bleeding abnormally	☐	☐	High Blood Pressure	☐	☐	Tuberculosis	☐	☐
(with extractions or surgery)			Jaundice	☐	☐	Tumors or Growths	☐	☐
Bruise easily	☐	☐	Jaw Pain	☐	☐	Ulcer	☐	☐
Cancer	☐	☐	Kidney Disease	☐	☐	Any Venereal Disease	☐	☐
Chemotherapy	☐	☐	Liver Disease	☐	☐	Weight loss-unexplained	☐	☐
Cough, Persistent/Bloody	☐	☐	Mitral Valve Prolapsed	☐	☐	**Women:**		
Diabetes	☐	☐	Pace maker	☐	☐	Pregnant	☐	☐
Epilepsy/Seizures	☐	☐	Radiation Treatment	☐	☐	Nursing	☐	☐
Fainting/Dizziness	☐	☐	Respiratory Disease	☐	☐	Taking birth control pills	☐	☐

Medications

Please list medications you are currently taking:

____

____

____

____

Allergies

Please list any drug allergies:

____

____

____

____

Pharmacy: ____________________________ Phone # _______________________

	Yes	No
Have any wounds healed slowly or presented other complications?	☐	☐
Do you have pain in or near your ear? ____	☐	☐
Does any part of your mouth hurt when clenched? _______________________________________	☐	☐
Have you ever had Novocaine anesthetic?	☐	☐
Any reactions or allergic symptoms to Novocaine?	☐	☐
Do your gums bleed? ____	☐	☐
Do you chew on only one side of your mouth? If so why? ________________________	☐	☐
Do you at the present time have any dental complaints? ________________________	☐	☐
Any part of your mouth sore to pressure or irritants (cold or sweets)? _______________	☐	☐

If so where? ____

Signature ____________________________________ Date ____________________

HIPAA

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

This notice describes how your dental information about you may be used and disclosed and how you can get access to this information.

I hereby authorize Premier Dental Center to share:

☐ Medical health information (health history, medications,allergies, etc.)

☐ Dental treatment

☐ Financials regarding dental treatment

☐ Appointment times,dates and reasons for the visit

☐ Other ____________________

with the following people:

____________________ ____________________
Full Name Relationship

____________________ ____________________
Full Name Relationship

This authoization does not have an expiration date. But I understand that I may cancel this consent at any time in writing.

____________________ ____________________
Signature of Patient or Legal Representative Date

____________________ ____________________
Printed Name of Legal Representative Relationship