PREMIER COSMETIC & FAMILY DENTISTRY

Patient Information

Patient Name: _____ Date of Birth: _____

Preferred Name: _____ Social Security #: _____

Gender: ☐ Male ☐ Female ☐Other **Family Status:** ☐ Married ☐ Single ☐ Child ☐ Other

Address: _____

City, State, Zip: _____ Email: _____

Home #: _____ Mobile #: _____ Work #: _____

How would you prefer to be contacted? ☐ Phone Call ☐ Text Message ☐ Email ☐ Mail

Whom may we thank for referring you to our practice? _____

Employer Name: _____ Phone #: _____

Employer Address: _____

City, State, Zip: _____ Email: _____

Spouse/Significant Other: _____ Date of Birth: _____

Preferred Name: _____ Social Security #: _____

Home #: _____ Mobile #: _____ Work #: _____

Primary Dental Insurance: _____

Phone #: _____ ID #: _____ Group #: _____

Policy Holder Name: _____ Relationship to patient: _____

Policy Holders SSN: _____ Policy Holders Date of Birth: _____

Secondary Dental Insurance: _____

Phone #: _____ ID #: _____ Group #: _____

Policy Holder Name: _____ Relationship to patient: _____

Policy Holders SSN: _____ Policy Holders Date of Birth: _____

Person Responsible for Bill: _____

PREMIER COSMETIC & FAMILY DENTISTRY

Medical and Dental History

Patient Name: _____ Date of Birth: _____

Primary Care Physician's name: _____Phone #: _____

Address: _____

Pharmacy: _____ **Pharmacy Location/Address:**_____

Prior Dentist Name: _____Phone # **:**_____

Address: _____

When was your last visit to the dentist? _____

Please take a moment to let us know about your medical and dental history so we may serve you more effectively and in a way that watches out for your overall health and well-being. Check mark below if you have or have had any of the following.

☐ Alcohol/Drug Abuse	☐ Allergy – Hay Fever	☐ Allergy – Amoxicillin	☐ Allergy – Iodine
☐ Allergy – Metal	☐ Allergy – Other Meds	☐ Allergy – Penicillin	☐ Allergy – Aspirin
☐ Allergy – Codeine	☐ Allergy – Latex	☐ Allergy – Local Anesth	☐ Allergy – Sulfa
☐ Anemia	☐ Arthritis	☐ Artificial Joints	☐ Asthma
☐ Blood Disease	☐ Blood Thinners	☐ Cancer	☐ Cold Sores
☐ Diabetes	☐ Dizziness/Fainting	☐ Epilepsy/Seizures	☐ Excessive Bleeding
☐ Glaucoma	☐ Growths/Tumors	☐ Head Injuries	☐ Heart Attack/Failure
☐ Heart Disease	☐ Heart Murmur	☐ Heart Pacemaker	☐ Hepatitis
☐ High Blood Pressure	☐ HIV	☐ Jaundice	☐ Kidney Disease
☐ Liver Disease	☐ Mental Disorders	☐ Mitral Valve Prolapse	☐ Nervous Disorders
☐ Osteoporosis	☐ Other	☐ Pre-Medicate	☐ Pregnancy
☐ Radiation Therapy	☐ Respiratory Problems	☐ Rheumatic Fever	☐ Rheumatism
☐ Sinus Problems	☐ Stomach Problems	☐ Stroke	☐ Thyroid Disease
☐ Tobacco Use	☐ Tuberculosis	☐ Ulcers	☐ Venereal Disease

Do you have any other health issues or allergies that are not listed above?

_____

_____

Have you or are you currently taking medications for bone density/osteoporosis such as Fosamax, Boniva, or any meds containing bisphosphonates?

- ☐ No
- ☐ Yes

Are you taking any medications?

- ☐ No
- ☐ Yes - Please list all medications you are currently taking below

______

_____

_____

_____

WOMEN ONLY: Are you pregnant

- ☐ No
- ☐ Yes – If yes, when is the due date? _____

Have you ever been told to take antibiotics prior to dental treatment?

- ☐ No
- ☐ Yes – If yes, please explain: _____

Have you ever had complications following dental treatment?

- ☐ No
- ☐ Yes – If yes, please explain: _____

What is the reason for your dental visit today?

_____

_____

How frequently do you brush your teeth?

☐ Never ☐ Seldom ☐ Weekly ☐ Once a Day ☐ Twice a Day ☐ 3+ times a day

How frequently do you floss your teeth?

☐ Never ☐ Seldom ☐ 1-6 times a month ☐ 2-6 times a week ☐ 1+ times a day

Do your gums bleed when you brush or floss? ☐ No ☐ Yes

Are any of your teeth currently causing you pain? ☐ No ☐ Yes

Do you currently have any dental implants, dentures, or partials? ☐ No ☐ Yes

Do your teeth experience sensitivity to cold or hot temperatures? ☐ No ☐ Yes

Do you grind your teeth (either consciously or during sleep)? ☐ No ☐ Yes

If you could change anything about your mouth, teeth, or smile, what would it be?

_____

_____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patients) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of patient, parent, or guardian: _____ **Date:** _____

Authorization

I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health.

I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate.

I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payors, and/or healthcare practitioners. I authorize the payment from my insurance carrier to submit payment directly to the dentist or dental practice to be applied directly to any outstanding balance on my account.

I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance, and I may be billed for this remaining balance. I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependents (if any).

HIPAA

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent, I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payers (e.g., my insurance company)

I have also been informed of and given the right to review and secure a copy of your Notices of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of the notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and healthcare operations, but that you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

By signing below, you acknowledge that you have read the above, understand, and agree with the contents.

Patient Name: _____ **Date of Birth:** _____

Signature: _____ **Date:** _____

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Consent for Services

I have completed the health questionnaire to the best of my knowledge. I declare all answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed unless other arrangements are made.

Patients with dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

I understand that any fee estimate for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment, or within five (5) days of billing if credit is extended.

I grant permission to you or your assignee, to telephone me to discuss this statement or my treatment.

By signing below, you acknowledge that you have read the above, understand, and agree with its contents.

Patient Name: _____ Date of Birth: _____

Signature: _____ Date: _____

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Broken Appointment Policy

When you reserve a time with us, please make every attempt to make your appointment. We do not "double book" as many offices do. This time is set aside specifically for you. Two weeks prior to your appointment, you will receive an email reminder. When you receive this, please either call to confirm the time that you have already reserved with us, or you have the option to confirm your scheduled appointment via email or text.

We have a 48-hour cancellation policy. If you need to change or reschedule your reserved time with us, please give us at least 48 hours of notice so that we will be able to fill this time with others waiting for treatment. If you cancel, fail to show for your appointment, or you arrive excessively late and treatment cannot be completed as planned, we recover our lost opportunity and associated costs for having our Staff on standby with a Broken Appointment Fee of $30.

The 1st offense will result in a letter to you re-iterating our policy. The 2nd offense will result in the Broken Appointment Fee of $30 applied to your account.

Late Arrival

If you are over 10 minutes late, we reserve the right to reschedule your appointment for a later time. Please understand that we strive to stay on time for your appointment as well as those patients that follow you.

By signing below, you acknowledge that you have read and understand this agreement.

Patient Name: _____ Date of Birth: _____

Signature: _____ Date: _____