Patient Information

Patient Name: ____ Date: __________
Last, First MI Preferred Name

Gender: M/F Social Security Number: _______________ Status: Single/Married

Birth Date: __________________ Home Phone: ____________________ Cell Phone: ________________________

Work Phone: ___________________ Ext. ____ E-Mail Address: ___________________________________

Street Address: ____ Apt. _________

City, State, Zip Code: ____

Dental Insurance Information

Policyholder Name: ______________________________________ D.O.B. _________

Policyholder Social Security Number: __________________________________

Insurance Company Name: _______________________________________

I.D. #: ___________________________ Group #: ______________________________

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. This practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment. Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

All emergency dental services, or any dental services performed without prior financial arrangements, must be paid for at the time services are performed.

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

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

In consideration for the professional services rendered unto me, or at my request, by the Doctor, I agree to pay the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form. I authorize release of any information relating to any insurance claims and also authorize payment of dental benefits otherwise payable to us directly, Premier Family Dentistry.

A $50.00 charge will be made for all missed appointments, unless a 24 hour notice is given.

I have read the above conditions of treatment and payment and agree to their content.

____ Date: ___________ Relationship to Patient: _______________
Signature of Patient or Guardian (Responsible Party)

Health Information

Date last Dental Visit: ________________ Reason for Today's Visit: ____________________

. . . .

Have you ever had any of the following? (Please check all that apply)

- ○ AIDS
- ○ Allergies ____________ ____________
- ○ Anemia
- ○ Angina
- ○ Artificial Joints
- ○ Artificial Heart Valve
- ○ Cancer
- ○ Chest Pain
- ○ Congenital Heart Defect
- ○ Convulsions
- ○ Diabetes
- ○ Dizziness
- ○ Epilepsy
- ○ Excessive Bleeding
- ○ Fainting
- ○ Glaucoma
- ○ Hay Fever
- ○ Heart Attack
- ○ Heart Murmur
- ○ Hemophilia
- ○ Hepatitis (Type:______)
- ○ Herpes
- ○ High/Low Blood Pressure
- ○ Jaundice
- ○ Kidney Disease
- ○ Low Salt Diet
- ○ Mental Disorders
- ○ Pregnancy (Present Due Date: ______)
- ○ Pacemaker
- ○ Mitral Valve Prolapse
- ○ Rheumatic Heart Disease
- ○ Sexually Transmitted Disease
- ○ Sinus Problems
- ○ Stomach Problems
- ○ Stroke
- ○ Thyroid Conditions
- ○ Tinnitus
- ○ Tuberculosis
- ○ Venereal Disease
- ○ Other: ____________ ____________

➢ Do you take any medications? Y/N
If yes, which ones? ____

➢ Are you allergic to any medications? Y/N
If yes, which ones? ____

➢ Are you presently under the care of a physician? Y/N
If yes, please explain: ____
Name of Physician: ____

➢ Do you smoke or use tobacco products? Y/N

➢ Do you have any health problems that need further clarification? Y/N
If yes, please explain: ____

To the best of my knowledge, all of the preceding answers and information are true and correct. If I ever have a change in my health, I will inform the doctor at the next appointment.

____ Date: ____________________
Signature of patient, parent, or guardian

Referral Section

To whom may we thank for inviting you to our practice? ______________________________

Dental Philosophy

How important is it that your teeth are pain-free and comfortable? Very/Somewhat/Not Important at all

How important is it that your teeth are attractive? Very/Somewhat/Not Important at all

How long would you like to keep your natural teeth? Forever/Not a Concern

Are there obstacles that prevent you from keeping your teeth healthy? Fear/Expense/Distrust/Insurance

Your Employer: ____

Your Position: ____

PREMIER FAMILY DENTISTRY
ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES*

*You may refuse to sign this acknowledgement

(Your Name)________________________________, has been offered a copy of this office's HIPAA Privacy Practices.

(Signature) ________________________________ (Date)____________________

FOR OFFICE PURPOSE ONLY

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

- Individual refused to sign
- Communication barriers prohibited us from obtaining signature
- An emergency situation prevented us from obtaining signature
- Other (Specify): ________________________

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