WELCOME

Patient Information

Today's Date_______________

Patient Name _______________

Date of Birth _______________

Social Security Number_______________

Mailing Address_______________

City_______________

State_______________ Zip _______________

E-mail_______________

Sex ☐ Male ☐ Female Age__________

☐ Married ☐ Widowed ☐ Single ☐ Minor
☐ Separated ☐ Divorced ☐ Other

Occupation_______________

Patient Employer_______________

Employer Address_______________

Work Phone Number_______________

Who may we thank for referring you?

____

Phone Numbers
Home: ( )_______________
Cell Phone: ( )_______________

Emergency Contact(s) (Specify someone who does not live in your household).

Name_______________ Relationship_______________
Home Phone ( )__________Work Phone ( )__________

For Self Paying Patients:

Who is responsible for account? _______________
Relationship to Patient? _______________

Dental Insurance Information

Who is responsible for this account? _______________
Relationship to Patient_______________

Subscriber Name _______________
Relationship_______________
Employer_______________
Primary Insurance_______________
Member ID Number _______________
Social Security Number_______________
Date of Birth _______________
Is patient covered by additional insurance?
☐ Yes ☐ No

Subscriber Name _______________
Relationship_______________
Employer_______________
Secondary Insurance_______________
Member ID Number _______________
Social Security Number_______________
Date of Birth _______________

Assignment and Release

I certify that I, and/or my dependent(s), have insurance coverage with

____
Name of Insurance Co.

and assign directly to Premier Dentistry all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Premier Dentistry may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

____
Signature of Patient, Parent, or Guardian or Personal Representative Date

____
Print Name of Patient, Parent, Guardian, or Personal Representative Date

____
Relationship to Patient

Premier Dentistry

Office Policies

Broken Appointment Policy: We understand that there are unforeseen circumstances that may arise; however, we ask that you contact our clinic 24 hours in advance if you are unable to keep your appointment. *Reminder calls are made as a courtesy. It is still your responsibility to call and inform us should you need to reschedule.* At the time of the first broken appointment, a $25.00 fee will be charged to your account. For a second missed appointment, a $50.00 fee will be charged to your account. The broken appointment fee MUST be paid before the next appointment is scheduled.

Financial Agreement Policy: I acknowledge that payment is due at the time of treatment. I agree that parents/ guardians are responsible for all fees and services rendered for treatment of a minor/child. I accept full financial responsibility for all charges to my account, and for the account(s) of my dependent child(ren). Methods of payment include cash and credit card such as Visa, Mastercard, or Discover. **Checks are not accepted.**

Credit Card Refunds: For credit card refunds, not caused by an error on our part, a 2% credit card transaction fee will be deducted from the refunded amount.

Privacy Practices Acknowledgement Policy: I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Minor/ Child Consent Policy: I, the parent/ guardian of ____________________________ do hereby request and authorize the dental staff to perform the necessary dental services for my child, including but not limited to, x-rays and administration of anesthetics per the doctor(s) recommendations. Patients 0-17 years old age must be accompanied by a parent or legal guardian. The parent/guardian must stay in the clinic from the start of treatment to the end of treatment. I understand that if I will not be present during my child's dental appointment, I must give written authorization to an adult who will accompany my child.

Child Supervision: Children 0-17 years of age must be supervised by an adult at all times. Children may not be left alone in the waiting area, unattended; nor may children (who are not patients) enter the treatment area. Parents/guardians who are undergoing treatment may not bring children to sit with them in treatment rooms. Please make other supervisory arrangements for your child(ren).

I acknowledge that I have read the above information and accept its contents.

____
Print Name of Patient/ Parent/ Guardian

____
Date

____
Patient/Parent/ or Guardian's Signature

Patient Name______________________ Date of Birth ______________________

Dental History

Check ☑ if you have had problems with any of the following:

- ☐ Bad Breath
- ☐ Grinding Teeth
- ☐ Sensitivity to hot
- ☐ Bleeding gums
- ☐ Loose Teeth or broken fillings
- ☐ Sensitivity to sweets
- ☐ Clicking or popping jaw
- ☐ Periodontal treatment
- ☐ Sensitivity when biting
- ☐ Sensitivity to cold
- ☐ Sores or growths in your mouth
- ☐ Food collection between teeth

Medical History

Physician's Name______________ Telephone Number__________ Date of Last Visit__________

Have you had any serious illnesses or operations? ____________ If yes, describe

____

Check ☑ if you have or have had any of the following:

- ☐ High Blood Pressure
- ☐ Heart Disease
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ Low Blood Pressure
- ☐ Stroke
- ☐ Rheumatic fever
- ☐ Angina
- ☐ Cardiac Pacemaker
- ☐ Anemia
- ☐ Fainting/Seizures
- ☐ Tuberculosis
- ☐ Epilepsy/Convulsions
- ☐ Asthma
- ☐ Emphysema
- ☐ Respiratory problems
- ☐ Cancer
- ☐ Radiation therapy
- ☐ Chemotherapy
- ☐ Leukemia
- ☐ Diabetes
- ☐ Liver Disease
- ☐ Kidney Disease
- ☐ Thyroid Disease
- ☐ Arthritis
- ☐ Joint Replacement
- ☐ Hepatitis
- ☐ Stomach trouble/Ulcers
- ☐ Swollen Ankles
- ☐ Recent Weight Loss
- ☐ Frequently Tired
- ☐ AIDS/ HIV infection
- ☐ Hay Fever/Allergies
- ☐ Sexually Transmitted Disease
- ☐ Other
- ☐ None

Comments____

Medications____ ☐ None

Allergies ☐ Latex ☐ Penicillin ☐ Sulfa Drugs ☐ Dental Anesthetics ☐ Aspirin ☐ Other ☐ None

____

Women

Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking Birth Control? ☐ Yes ☐ No

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered and I understand that providing incorrect information can be dangerous to my health.

______________________________ ______________

Patient, Parent, or Guardian's Signature Date

PREMIER DENTISTRY
REQUEST FOR RESTRICTION OF THE USE OR DISCLOSURE OF PHI

Patient's Name: ______________________________ Date of Birth: ____________________

Patient's Address: ____

Patient's Phone #: ____________________

It is hereby requested that the employees of Premier Dentistry honor the following restrictions regarding the use and/or disclosure of the protected health information of the individual indicated above.

Please check the type(s) of disclosure to be restricted:

☐ Use and/or disclosure relating to treatment, payment and/or healthcare operations of individual listed above

☐ Use and/or disclosure relating to prescriptions, medical supplies, X-rays or other similar forms of protected health information.

The following persons are exceptions to the restrictions checked above:

Date PHI Access Granted	Name of Individual	Individual/ Guardian's Initials	Date Access Revoked	Initials for Revocation	Specific Instructions

- Information will *not* be given over the phone
- Photo ID will be required.

____ Date____________________

Signature of Individual/Patient

______________________________ ______________________________

Printed Name Individual/Patient *Relationship to Individual (if not patient/employee)*

____

Address (if other than patient's address)

Limitations to Restrictions on Disclosure of Protected Health Information for Treatment, Payment or Health Care Operations

For treatment. The Health Care Providers may use and disclose your health information to provide or assist with your treatment. For example, we may provide your health information to a laboratory in order to obtain a test result important for diagnosing or treating a condition you may have.

To obtain payment for health care services. We may use and disclose your health information in order to bill and collect payment for the treatment and services provided to you. For example, we may provide limited portions of your health information to your health plan to get paid for the health care services we provide to you. We may also provide your health information to our business associates who assist us with billing, such as billing companies, claims processing companies, and others that process our health care claims. We will only disclose the minimum amount of information needed to obtain payment.

For health care operations. Your health information may also be used or disclosed to improve and conduct health care operations. For example, we may use your health information in order to evaluate the quality of health care services that you received, or to evaluate the performance of the health care professionals who provided health care services to you. We may also provide your health information to our auditors, attorneys, consultants, and others in order to make sure we are complying with the laws that affect us. We may also use a sign-in sheet at registration or other appropriate areas, and we may call you by name in waiting and service areas.