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?

_____

Patient Contact 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
Clinic Policies (updated 2021)

Broken Appointment Policy: I understand broken appointments are both costly and inconsiderate. If for some reason, I am unable to keep my appointment, I am aware that I must contact Premier Dentistry **at least 48 hours in advance (for surgeries) and 24 hours in advance (for all other appointments).** I understand that reminder calls are made as a courtesy and that it is my responsibility to keep track of my appointment or to re-schedule in a timely manner. I acknowledge that there is a **$100.00 broken appointment fee** (for surgery-related appointments) and a **$50.00 broken appointment fee** (for all other procedures), and that the fee will automatically be charged to my account. I understand that the fee must be paid BEFORE I will be permitted to re-schedule. I further acknowledge that if I fail to keep my appointment a second time, the fees will double; and if a third broken appointment occurs, I will no longer be accepted as a patient at Premier Dentistry. **Initial:** _____

Financial Agreement Policy: I acknowledge that **payment is due at the time of treatment** and that there are no extended payment plans. In the case of minor patients, I agree that as parents/ guardians, I am 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. Personal checks are not accepted. **Initial:** _____

Credit Card Refunds: For credit card refunds not caused by an error on the part of Premier Dentistry, I acknowledge that a 3% credit card transaction fee will be deducted from the refunded amount. **Initial:** _____

Privacy Policy Acknowledgement: I have received and reviewed the Notice of Privacy Practices and accept the contents of the Notification. **Initial:** _____

Minor/ Child Consent Policy: I, the parent/ guardian of _____ do hereby authorize the dental staff of Premier Dentistry to perform all necessary dental services for my child, including but not limited to, x-rays, administration of anesthetics, full dental treatment plan, per the doctor's recommendations. I understand that patients under 18 years of age MUST be accompanied by a parent or legal guardian, and that the parent/guardian must remain in the clinic from the start of treatment to its completion. I understand that if I cannot be present during my child's dental appointment, I must provide written authorization to an adult who will accompany my child. **Initial:** _____

Child Supervision: Children under 18 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. A parent or guardian who are undergoing treatment may not bring children to sit with them in treatment rooms. The clinic does not offer babysitting services. Please make other supervisory arrangements for your child(ren). **Initial:** _____

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

_____ _____

Print Name of Patient/ Parent or Guardian Date

_____

Signature of Patient/Parent or Guardian