

# Premiere Dentistry

The benefits of a happy, healthy smile are immeasurable. Our goal is to help you reach maximum oral health!

Please fill out this form completely. The better we can communicate, the better we can care for you.

**1**

## About Patient

Today's Date \_\_\_\_\_

Name \_\_\_\_\_  
First M. Last

SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  Male

Birth Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age \_\_\_\_  Female

Mailing Address \_\_\_\_\_

City \_\_\_\_\_ St. \_\_\_\_\_ Zip \_\_\_\_\_

Physical Address \_\_\_\_\_

City \_\_\_\_\_ St. \_\_\_\_\_ Zip \_\_\_\_\_

Single  Married  Divorced  Widowed

Home Phone # (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Cell Phone # (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Work # (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Ext. \_\_\_\_\_

Best Phone # to reach you between 8 – 5? \_\_\_\_\_

Employer \_\_\_\_\_

Employer's Address \_\_\_\_\_

How long there \_\_\_\_\_ Occupation \_\_\_\_\_

E-mail Address \_\_\_\_\_

**2**

## Spouse/Parent Information

Parent  Spouse

Name \_\_\_\_\_

Employer \_\_\_\_\_

Work # (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Ext. \_\_\_\_\_

SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Birth Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

### PERSON RESPONSIBLE FOR ACCOUNT (MUST SIGN THE FINANCIAL POLICY)

Name \_\_\_\_\_

Address \_\_\_\_\_

Work # (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Home # (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Birth Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Relation \_\_\_\_\_ Employer \_\_\_\_\_

**3**

## Dental Insurance

IF YOU DO NOT HAVE INSURANCE OR MEDICAID, PAYMENT IS DUE IN FULL ON DATE OF SERVICE. IF YOU HAVE INSURANCE, YOUR ESTIMATED CO-PAY IS DUE ON THE DATE OF SERVICE.

**DO YOU HAVE DENTAL INS?**  Yes  No

Insurance Co. Name \_\_\_\_\_

Subscriber Name \_\_\_\_\_

Subscriber Address \_\_\_\_\_

SS#/ID# \_\_\_\_\_ Birth Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Relation to Patient \_\_\_\_\_

Employer Name \_\_\_\_\_

Employer Address \_\_\_\_\_

Employer Phone # (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**DO YOU HAVE SOONERCARE/MEDICAID?**

Yes  No

ID # \_\_\_\_\_

**DO YOU HAVE SECONDARY INS?**  Yes  No

Insurance Co. Name \_\_\_\_\_

Subscriber Name \_\_\_\_\_

Subscriber Address \_\_\_\_\_

SS#/ID# \_\_\_\_\_ Birth Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Relation to Patient \_\_\_\_\_

Employer Name \_\_\_\_\_

Employer Address \_\_\_\_\_

Employer Phone # (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**4**

## Emergency Information

Someone to contact, in the event of an emergency:

Name \_\_\_\_\_

Relation \_\_\_\_\_

Phone # (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ or (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

# 5

## Medical History

1. Medical Doctor's Name \_\_\_\_\_ Phone # \_\_\_\_\_
2. Are you currently under the care of your medical doctor?  No  Yes, \_\_\_\_\_
3. Have you had any serious illnesses or operations?  No  Yes, \_\_\_\_\_
4. Do you need to be pre-medicated due to heart murmur, rheumatic fever, mitral valve prolapse, or joint replacement?  Yes  No
5. Date of last dental visit? \_\_\_\_\_
6. (WOMEN) Are you PREGNANT?  Yes  No Taking Birth Control Pills?  Yes  No  
If Yes – Expected Due Date? \_\_\_\_\_

Please place a  in the box if you have or have had any of the following:

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Anemia   | <input type="checkbox"/> Dizziness / Fainting | <input type="checkbox"/> Mitral Valve Prolapse       |
| <input type="checkbox"/> Arthritis  | <input type="checkbox"/> Drug / Alcohol Abuse | <input type="checkbox"/> Mental Disorders            |
| <input type="checkbox"/> Artificial bones or joints                                   | <input type="checkbox"/> Dry Socket           | <input type="checkbox"/> Panic Attacks / Nervousness |
| <input type="checkbox"/> Blood Disease  | <input type="checkbox"/> Epilepsy             | <input type="checkbox"/> Radiation Treatment         |
| <input type="checkbox"/> Blood Pressure   | <input type="checkbox"/> Heart Attack         | <input type="checkbox"/> Rheumatic Fever             |
| <input type="checkbox"/> <input type="checkbox"/> High <input type="checkbox"/> Low   | <input type="checkbox"/> Heart Murmur         | <input type="checkbox"/> Seizures                    |
| <input type="checkbox"/> Blood Transfusions   | <input type="checkbox"/> Heart Surgery        | <input type="checkbox"/> Stomach Problems            |
| <input type="checkbox"/> Breathing Difficulties                                       | Explain _____                                 | <input type="checkbox"/> Stroke                      |
| <input type="checkbox"/> Cancer / Chemotherapy  | <input type="checkbox"/> Hepatitis A B or C   | <input type="checkbox"/> Tobacco Use                 |
| <input type="checkbox"/> Congenital Heart Disease                                     | How long ago? _____                           | <input type="checkbox"/> Tuberculosis                |
| <input type="checkbox"/> Diabetes   | <input type="checkbox"/> HIV / AIDS           | How long ago? _____                                  |
| <input type="checkbox"/> Have you taken Phen Fen<br>(also known as Redux or Pondimin) | <input type="checkbox"/> Kidney Problems      | <input type="checkbox"/> Venereal Disease            |
|   |   | How long ago? _____                                  |

# 6

## Medications

List any medications you are currently taking:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Pharmacy Name \_\_\_\_\_

Phone # \_\_\_\_\_

# 7

## Medical Allergies

Do you have any known allergies?  Yes  No

- |                                       |   |
|---------------------------------------|---|
| <input type="checkbox"/> Aspirin      | <input type="checkbox"/> Local Anesthetic |
| <input type="checkbox"/> Codeine      | <input type="checkbox"/> Penicillin       |
| <input type="checkbox"/> Erythromycin | <input type="checkbox"/> Sulfa Drugs      |
| <input type="checkbox"/> Latex        | <input type="checkbox"/> Tetracycline     |
| <input type="checkbox"/> Other, _____ |   |

# 8

## Authorization, Release, and Agreement to Pay For Services Rendered

I authorize the Dentist to release any information acquired in the course of my Treatment to third party payers and/or health practitioners.

I authorize and hereby request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me.

I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or on behalf of my dependents.

I understand my account is payable within 30 days or a finance charge of 1.5% will be charged on the unpaid balance.

\_\_\_\_\_  
Patient Signature or Parent if minor

\_\_\_\_\_  
Date

D.D.S. \_\_\_\_\_ Hyg/Ast \_\_\_\_\_