

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.

Signature of Patient or Guardian (Responsible Party) Date: _____ Relationship to Patient: _____

Health Information

Date last Dental Visit: _____ Reason for Today's Visit: _____

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

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

- 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.

Signature of patient, parent, or guardian

Date: _____

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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