# WELCOME to Our Premier Family!
# SMILES Change Lives!!

**How Did You Hear About Our Office?**_____

**What is your Primary Goal for today's visit?**_____

Date_____

**PATIENT**

Last _____First _____MI_____Preferred Name_____

**M**ale/**F**emale_____ **M**arried, **S**ingle, **C**hild, **O**ther_____ Birth Date_____

Social Security#_____ Driver License_____

Mailing Address _____City_____ST_____Zip_____

E-Mail Address_____ Employer_____

Mobile_____Home_____Work_____Other_____

**PARENT / GUARDIAN**

Last _____First _____MI_____Preferred Name_____

**M**ale/**F**emale_____ **M**arried, **S**ingle, **O**ther_____ Birth Date_____

Social Security#_____ Driver License_____

Mailing Address _____City_____ST_____Zip_____

E-Mail Address_____ Employer_____

Mobile_____Home_____Work_____Other_____

**PRIMARY DENTAL INSURANCE**

Please Circle: SELF SPOUSE/SO PARENT/GUARDIAN OTHER

Last _____First _____MI_____

Mailing Address _____City_____ST_____Zip_____

Birth Date_____ Social Security#_____

Employer_____

Insurance Company_____Phone_____

Policy ID/Member ID/Employee ID_____Group ID_____

**SECONDARY DENTAL INSURANCE**

Please Circle: SELF SPOUSE/SO PARENT/GUARDIAN OTHER

Last _____First _____MI_____

Mailing Address _____City_____ST_____Zip_____

Birth Date_____ Social Security#_____

Employer_____

Insurance Company_____Phone_____

Policy ID/Member ID/Employee ID_____Group ID_____

## MEDICAL HISTORY

*Check ALL that apply*

- ◯ Alcohol/Drug Addiction
- ◯ Allergy - Codeine
- ◯ Allergy - Eggs
- ◯ Allergy - Hydrocodone
- ◯ Allergy - Keflex
- ◯ Allergy - Latex
- ◯ Allergy - Penicillin
- ◯ Allergy - Soy
- ◯ Allergy - Sulfa
- ◯ Alzheimer's
- ◯ Anemia
- ◯ Anxiety/Depression
- ◯ Arthritis
- ◯ Artificial Joint
- ◯ Asthma
- ◯ Blood Disease
- ◯ Cancer
- ◯ Current Smoker
- ◯ Diabetes, Type_____ Avg Sugar Level_____
- ◯ Diverticulitis / IBS
- ◯ Dizziness
- ◯ Dry Mouth /Sjogren's
- ◯ Epilepsy/Seizures
- ◯ Excessive Bleeding
- ◯ Fainting
- ◯ Gastric Reflux Disease
- ◯ Glaucoma
- ◯ Growths
- ◯ Heart Disease
- ◯ Heart Murmur
- ◯ Hepatitis, Type _____
- ◯ High Blood Pressure
- ◯ HIV / AIDS
- ◯ Indoor/Outdoor Allergies
- ◯ Jaundice
- ◯ Kidney Disease
- ◯ Liver Disease
- ◯ Mental Disorder
- ◯ Mitral Valve Prolapse
- ◯ Mouth Ulcers
- ◯ Pacemaker
- ◯ Currently Pregnant
- ◯ Pre-Medication
- ◯ Radiation Treatment
- ◯ Respiratory Problems
- ◯ Restless Leg Syndrome
- ◯ Rheumatism
- ◯ Sinus Problems
- ◯ Stomach Problems
- ◯ Stroke
- ◯ Take Baby Aspirin
- ◯ Take Birth Control
- ◯ Take Blood Thinner
- ◯ Take Cholesterol Med
- ◯ Take Fish Oil
- ◯ Take MultiVit / Vit E
- ◯ Tobacco Use
- ◯ Traumatic Brain Injury
- ◯ Tuberculosis
- ◯ Tumor
- ◯ OTHER Drug Allergies ***Listed Below***
- ◯ OTHER Medical Condition(s) ***Below***

**Other Drug Allergies**_____ _____ _____

**Conditions you are currently visiting your medical physician/specialist for**

**Physician** _____City_____Phone_____

Condition 1_____Condition 2_____Condition 3_____

**Physician** _____City_____Phone_____

Condition 1_____Condition 2_____Condition 3_____

**Pharmacy** _____City_____Phone_____

**Current Medications including Vitamins/Supplements**

_____ _____ _____ _____

_____ _____ _____ _____

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

**Patient/Legal Guardian Signature**_____ **Date**_____

## EMERGENCY CONTACT

**Name**_____ **Phone**_____

**Relation**_____

## DENTAL HISTORY

Previous dental treatment and approximate date(s)

_____

Explain any dental complications you experienced and/or any anxiety about visiting your dentist

_____

What do you like about your smile?_____

What would you change about your smile?_____

How can we EXCEED your expectations today and/or in the future?_____

## PATIENT AGREEMENT – *Please Initial*

_____ I authorize Premier Dentistry to review my medical history and prescription formulations for the purpose of evaluating and diagnosing my oral condition.

_____ I understand that digital radiography is necessary to accurately diagnose my oral condition. I understand that digital radiography exposes me to 80-90% LESS radiation than traditional dental x-rays, and that radiation exposure from traditional dental x-rays is 1/100th of the amount of radiation obtained from natural sources in the US each year.

_____ As in all medical/dental treatment, I understand there are known and unknown risks; and I understand that I am encouraged to ask questions about my condition and my treatment at any time.

_____ I authorize Premier Dentistry to release information relevant to my oral condition to my insurance company, consulting physicians/dental specialists, pathology and/or restorative laboratories, and any other entity which may be involved in my care.

_____ I understand that my insurance policy is a contract between my insurance company and me, and that Premier Dentistry will file my insurance claims as a professional courtesy. Thus, I hereby assign all insurance benefits/payments to Premier Dentistry paid in conjunction for dental services, prosthetics, materials, supplies, etc. rendered to me at Premier Dentistry.

_____ I agree to pay all expenses incurred from my dental evaluation and treatment less any ESTIMATED insurance benefits. I agree to pay my ESTIMATED portion for treatment prior to services being rendered. I agree to pay in full any outstanding balance remaining after my insurance company has processed all claims for services rendered by me/my dependent.

_____ I understand that I am responsible for payment in full or initiating a payment arrangement with Premier Dentistry for my outstanding balance within 14 days of my first invoice if I cannot pay by the due date on the statement. I agree to pay 10% interest accrued monthly and a 5% delinquency fee accrued monthly on all balances left on my account beginning on the 30th day after the date on which the balance is due (Tex.Fin.Code.Ann.§302.001). I agree to pay all attorney costs incurred on my account due to an outstanding balance left on my account after 1 year of non-payment.

_____ I understand that my appointments serve as a specific date/time reservation to see my dental provider and that countless preparations have been made in anticipation of my participation in my oral care. Thus, I agree to give Premier Dentistry at least 48 hours prior notice of my scheduled changes, or I will incur a $45 no show/cancellation charge.

_____ I understand that at any time I feel uncomfortable regarding my oral health, my treatment plan, dental and/or administrative services rendered, financing, internal payment arrangements, the appearance of the facility, etc. that I will have open, honest and productive communication with a staff member at Premier Dentistry.

Signature_____Date_____

## HIPAA PRIVACY PRACTICES

I have received a copy of Notice of Privacy Practices. I give my permission to the following person(s) to discuss my medical/dental health and/or financial information as it pertains to my dental care and/or payment of my care.

Name_____ Relation_____

Name_____ Relation_____