PREMIERE DENTAL

Patient Information

Name: _____ Preferred Name: _____

Mailing Address: _____

City: _____ State: _____ Zip_____

Cell: _____ Home: _____ DOB: _____

Email: _____ Gender: _____

Check appropriate response: Minor ____ Single ____ Married____

Emergency Contact

Name: _____ Phone: _____ Relation: _____

Responsible Party (for patients who are under the age of 18)

Name: _____ DOB: _____

Cell: _____ Home: _____ Relationship to Patient: _____

Email: _____

Dental Insurance

Insurance Company: _____

Name of Insured: _____ DOB: _____

Relationship to Patient: _____ Employer: _____

Social Security # _____ Policy I.D # _____

If you have secondary insurance, please fill out the information below:

Insurance Company: _____

Name of Insured: _____ DOB: _____

Relationship to Patient: _____ Employer: _____

Social Security # _____ Policy I.D # _____

Signature: _____ Date: _____

PREMIERE DENTAL

Medical History Form

Patient Name: _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medications that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions

1.) Are you under a physicians care now? Y ☐ N ☐

2.) Have you ever been hospitalized or had a major operation? Y ☐ N ☐

3.) Have you had a serious head or neck injury? Y ☐ N ☐

4.) Are you taking any medications, pills, or drugs? Y ☐ N ☐

5.) Do you take or have taken, Phen-Fen or Redux? Y ☐ N ☐

6.) Have you ever taken Fosamax, Bonica, Actonel or any other medications containing bisphosphonates? Y ☐ N ☐

7.) Are you on a special diet? Y ☐ N ☐

8.) Do you use tobacco? Y ☐ N ☐

9.) Do you use controlled substances? Y ☐ N ☐

Women: Are you…

- Pregnant/Trying to get pregnant? Y ☐ N ☐
- Nursing? Y ☐ N ☐
- Taking Oral contraceptives? Y ☐ N ☐
-

Are you allergic to any of the following? Mark only if NO for all ☐

- Aspirin Y ☐ N ☐
- Codeine Y ☐ N ☐
- Metal Y ☐ N ☐
- Sulfa drugs Y ☐ N ☐
- Penicillin Y ☐ N ☐
- Acrylic Y ☐ N ☐
- Latex Y ☐ N ☐
- Local Anaesthetics Y ☐ N ☐
- Other Y ☐ N ☐ _____

Do you have, or have had any of the following?

Mark the appropriate response

MARK THIS BOX IF THE ANSWER IS NO TO ALL ☐

☐ AIDS/HIV Positive	☐ Arthritis/Gout	☐ Blood Transfusion	☐ Chest Pains
☐ Cortisone Medicine	☐ Epilepsy/Seizure	☐ Frequent Diarrhea	☐ Heart Attack/Failure
☐ Hemophilia	☐ High Cholesterol	☐ Leukemia	☐ Osteoporosis
☐ Radiation Treatment	☐ Scarlet Fever	☐ Stomach/Intestinal Disease	☐ Tuberculosis
☐ Alzheimer's Disease	☐ Artificial Heart Valve	☐ Breathing Problems	☐ Cold Sores/Fever Blisters
☐ Diabetes	☐ Excessive Bleeding	☐ Frequent Headaches	☐ Heart Murmur
☐ Hepatitis A	☐ Hives or Rash	☐ Liver Disease	☐ Pain in Jaw Joints
☐ Recent Weight Loss	☐ Shingles	☐ Stroke	☐ Tumors or Growths
☐ Anaphylaxis	☐ Artificial Joint	☐ Bruise Easily	☐ Congenital Heart Disorder
☐ Drug Addiction	☐ Excessive Thirst	☐ Genital Herpes	☐ Heart Pacemaker
☐ Hepatitis B or C	☐ Hypoglycemia	☐ Low Blood Pressure	☐ Parathyroid Disease
☐ Renal Dialysis	☐ Sickle Cell Disease	☐ Swelling of Limbs	☐ Ulcers
☐ Anemia	☐ Asthma	☐ Cancer	☐ Convulsions
☐ Easily Winded	☐ Fainting Spells/Dizziness	☐ Glaucoma	☐ Heart Trouble/Disease
☐ Herpes	☐ Irregular Heartbeat	☐ Lung Disease	☐ Psychiatric Care
☐ Rheumatic Fever	☐ Sinus Trouble	☐ Thyroid Disease	☐ Venereal Disease
☐ Angina	☐ Blood Disease	☐ Chemotherapy	☐ Yellow Jaundice
☐ Emphysema	☐ Frequent Cough	☐ Hay Fever	☐ High Blood Pressure
☐ Kidney Problems	☐ Mitral Valve Prolapse	☐ Rheumatism	☐ Spina Bifida
☐ Tonsilitis			

Have you ever had any serious illness not listed above? _____

Signature: _____ Date: _____

IX. Our Right to Change Our Privacy Practices and This Notice

We reserve the right to change the terms of this Notice at any time. Any change will apply to the health information we have about you or create or receive in the future. We will promptly revise the Notice when there is a material change to the uses or disclosures, individual's rights, our legal duties, or other privacy practices discussed in this Notice. We will post the revised Notice on our website (if applicable) and in our office and will provide a copy of it to you on request. The effective date of this Notice is 04/21/2020.

X. How to Make Privacy Complaints

If you have any complaints about your privacy rights or how your health information has been used or disclosed, you may file a complaint with us by contacting our Privacy Official listed on the first page of this Notice.
You may also file a written complaint with the Secretary of the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you in any way if you choose to file a complaint.

Print Name: _____

Patient's Signature: _____ Date: _____

Appointment Cancellation Policy

First Name *
-

Middle Name
-

Last Name *
-

Appointment Cancellation Policy

We strive to render excellent dental care to you and the rest of our patients. In an attempt to be consistent with this, we have an **Appointment Cancellation Policy** that allows us to schedule appointments for all patients. When an appointment is scheduled, that time has been set aside for you and when it is missed, that time cannot be used to treat another patient.

Our policy is as follows:

We require that you give our office a **24-hour notice** in the event that you need to reschedule your appointment. This allows for other patients to be scheduled into that appointment. If you miss an appointment without contacting our office within the required time, this is considered a missed appointment. A fee of $50.00 will be charged to you; this fee cannot be billed to your insurance company and will be your direct responsibility. No future appointments can be scheduled nor can records be transferred without the payment of this fee.

We thank you for your patronage.

SIgnature *
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