

  
**PREMIER SMILE**  
— C E N T E R —

**Section I**

**Patient Information**

**Date** \_\_\_\_\_

Name: \_\_\_\_\_ I Prefer to be called: \_\_\_\_\_

Address: \_\_\_\_\_ APT \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip \_\_\_\_\_

Phone (\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_

The best time to contact me is: \_\_\_\_\_  A.M.  P.M. on my  Home phone  Work phone  Cell

Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Check Appropriate Box:  Minor  Single  Married  Partnered  Separated  Divorced  Widowed

Sex:  Male  Female Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Spouse or Parent's Name: \_\_\_\_\_ Employer \_\_\_\_\_ Phone \_\_\_\_\_

How did you hear about us?/Whom may we thank for referring you? \_\_\_\_\_

Person to contact in case of emergency \_\_\_\_\_ Phone \_\_\_\_\_

Email Address \_\_\_\_\_

Would you like to receive our e-newsletter?  Yes  No

**Section II**

**Responsible Party**

Relationship to Patient:  Self  Spouse  Parent  Other

Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_ SSN# \_\_\_\_\_

**Section III**

**Dental Health**

Reason for visit: \_\_\_\_\_

When was your last dental visit? \_\_\_\_\_

Have you ever had any serious problem associated with previous dental treatment?  Yes  No

If so, explain: \_\_\_\_\_

\_\_\_\_\_

## Medical History

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

Are you under a physician's care now?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please explain: _____
Have you ever been hospitalized or had a major operation?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please explain: _____
Have you ever had a serious head or neck injury?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please explain: _____
Are you taking any medications, pills or drug?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please explain: _____
Do you take, or have you take, Phen-Fen or Redux?	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Are you on a special diet?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you use tobacco?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you use controlled substances?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

**Women:** Are you  
 Pregnant/Trying to get pregnant?  Yes  No    Taking Oral Contraceptives?  Yes  No    Nursing?  Yes  No

**Are you allergic to any of the following?**

Aspirin     Penicillin     Codeine     Local Anesthetics     Acrylic     Metal     Latex     Sulfa Drugs  
 Other    If yes, please explain: \_\_\_\_\_

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

AIDS/HIV Positive <input type="checkbox"/> Yes <input type="checkbox"/> No	Cortisone Medicine <input type="checkbox"/> Yes <input type="checkbox"/> No	Hemophilia <input type="checkbox"/> Yes <input type="checkbox"/> No	Radiation Treatments <input type="checkbox"/> Yes <input type="checkbox"/> No
Alzheimer's Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis A <input type="checkbox"/> Yes <input type="checkbox"/> No	Recent Weight Loss <input type="checkbox"/> Yes <input type="checkbox"/> No
Anaphylaxis <input type="checkbox"/> Yes <input type="checkbox"/> No	Drug Addiction <input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis B or C <input type="checkbox"/> Yes <input type="checkbox"/> No	Renal Dialysis <input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia <input type="checkbox"/> Yes <input type="checkbox"/> No	Easily Winded <input type="checkbox"/> Yes <input type="checkbox"/> No	Herpes <input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever <input type="checkbox"/> Yes <input type="checkbox"/> No
Angina <input type="checkbox"/> Yes <input type="checkbox"/> No	Emphysema <input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatism <input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis/Gout <input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy or Seizures <input type="checkbox"/> Yes <input type="checkbox"/> No	High Cholesterol <input type="checkbox"/> Yes <input type="checkbox"/> No	Scarlet Fever <input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Heart Valve <input type="checkbox"/> Yes <input type="checkbox"/> No	Excessive Bleeding <input type="checkbox"/> Yes <input type="checkbox"/> No	Hives or Rash <input type="checkbox"/> Yes <input type="checkbox"/> No	Shingles <input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Joint <input type="checkbox"/> Yes <input type="checkbox"/> No	Excessive Thirst <input type="checkbox"/> Yes <input type="checkbox"/> No	Hypoglycemia <input type="checkbox"/> Yes <input type="checkbox"/> No	Sickle Cell Disease <input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No	Fainting/Dizziness <input type="checkbox"/> Yes <input type="checkbox"/> No	Irregular Heartbeat <input type="checkbox"/> Yes <input type="checkbox"/> No	Sinus Trouble <input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	Frequent Cough <input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Problems <input type="checkbox"/> Yes <input type="checkbox"/> No	Spina Bifida <input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Transfusion <input type="checkbox"/> Yes <input type="checkbox"/> No	Frequent Diarrhea <input type="checkbox"/> Yes <input type="checkbox"/> No	Leukemia <input type="checkbox"/> Yes <input type="checkbox"/> No	Stomach/Intestinal Disease <input type="checkbox"/> Yes <input type="checkbox"/> No
Breathing Problems <input type="checkbox"/> Yes <input type="checkbox"/> No	Frequent Headaches <input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke <input type="checkbox"/> Yes <input type="checkbox"/> No
Bruise Easily <input type="checkbox"/> Yes <input type="checkbox"/> No	Genital Herpes <input type="checkbox"/> Yes <input type="checkbox"/> No	Low Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No	Swelling of limbs <input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma <input type="checkbox"/> Yes <input type="checkbox"/> No	Lung Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Disease <input type="checkbox"/> Yes <input type="checkbox"/> No
Chemotherapy <input type="checkbox"/> Yes <input type="checkbox"/> No	Hay Fever <input type="checkbox"/> Yes <input type="checkbox"/> No	Mitral Valve Prolapse <input type="checkbox"/> Yes <input type="checkbox"/> No	Tonsillitis <input type="checkbox"/> Yes <input type="checkbox"/> No
Chest Pains <input type="checkbox"/> Yes <input type="checkbox"/> No	Heart attack/Failure <input type="checkbox"/> Yes <input type="checkbox"/> No	Osteoporosis <input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis <input type="checkbox"/> Yes <input type="checkbox"/> No
Cold Sores <input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Murmur <input type="checkbox"/> Yes <input type="checkbox"/> No	Pain in Jaw Joints <input type="checkbox"/> Yes <input type="checkbox"/> No	Tumors or Growths <input type="checkbox"/> Yes <input type="checkbox"/> No
Congenital Heart Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Pacemaker <input type="checkbox"/> Yes <input type="checkbox"/> No	Parathyroid Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcers <input type="checkbox"/> Yes <input type="checkbox"/> No
Convulsions <input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Trouble/Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care <input type="checkbox"/> Yes <input type="checkbox"/> No	Venereal Disease <input type="checkbox"/> Yes <input type="checkbox"/> No
			Yellow Jaundice <input type="checkbox"/> Yes <input type="checkbox"/> No

**Comments:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any change in medical status.**

Signature of Patient, Parent, or Guardian

Date



**Welcome to our Premier Smile Family!** We aim to make your payment for dental services as convenient as possible. The following information is provided for your understanding. Our practice works on the belief that by eliminating the billing process we keep down our cost of dental services to you. If at any time you have questions or concerns regarding your treatment plan and financial responsibility, please do not hesitate to discuss these with our Office Specialists.

**Insurance Patients:** Office policy requires verification of insurance. Insurance is a patient's responsibility, however, our office will be glad to submit your claim if proper information is received, and can be verbally verified with the insurance company. We will apply any payment received from the insurance company to your account. However, it is the patient's responsibility for any difference between what is billed and what is paid. Your estimated patient portion and deductibles are due at the time of scheduling or service as well as any co-insurance payments. Please note that any communication with the insurance company is not a guarantee of payment by them and that the insurance contract is between you and your carrier. Any non-payment by the insurance company is the full responsibility of the patient.

**Pre-payment:** For Dental treatment of \$1000.00 or greater, we offer a 5% bookkeeping courtesy on payment made in full at the time of scheduling.

**In House Financial Arrangement:** If for extended treatment only, we will also offer an in-house plan within the office limit of 90 days. We also offer the convenience of credit card authorization on a timely basis to help in eliminating the billing process. We will discuss this option with you once your treatment plan has been outlined and presented to you.

**Financing:** For those who prefer the convenience of payments spread out over a comfortable period of time, we also offer a couple independent financial companies which may be helpful. Please speak to our Treatment Plan Coordinator regarding these arrangements.

*I have read and understand the payment policy. I understand that I am responsible for all fees charged to me for dental services rendered.*

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Signature of Patient, Parent, or Guardian

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Date