PREMIER DENTAL CENTER

Patient Information

Date:_____

Patient First Name:_____Patient Last Name:_____Birthday:_____

Preferred Name(if different):_____Social Security No:_____

Home Address:_____

City:_____State:_____Zip:_____

Primary Phone:_____ Is this a cell phone? Yes No **Text/Email OK?** Yes No

Email: _____

*We will send account information, appointment reminders, and other dentistry related emails periodically.

How did you hear about our office?

- o Facebook
- o Google
- o Website
- o TV Ad
- o Patient/Family Member:_____
- o PDC Employee:_____
- o Doctor Referral:_____

Emergency Contact:_____Relationship:_____Phone:_____

DENTAL INSURANCE

Subsriber Name:_____DOB:_____Social Security #:_____

Insurance Company:_____ Employer:_____Group #_____

Subsriber ID:_____ Relationship to Subscriber:_____

Secondary Insurance:

Subsriber Name:_____DOB:_____Social Security #:_____

Insurance Company:_____ Employer:_____Group#:_____

Subsriber ID:_____ Relationship to Subscriber:_____

Are you interested in receiving information about any of these services below? (Please check all that apply)

_____ Bleaching(tooth whitening) _____ Braces/Invisalign _____ Porcelain Veneers

_____ Implants _____ Botox

Health History

Date of last **medical** exam: _____ What was this exam for? _____
Date of last **dental** exam: _____

Have you been hospitalized in the last 5 years? Yes _____ No _____
If yes, reason for hospitalization: _____

Are you currently receiving care? Yes _____ No _____
If yes, nature of care: _____

Please list the names/phone number of the physicians who are currently providing you care:
Name: _____ Phone #: _____

Do you have or have you ever had any of the following medical conditions? (Please check yes/no)

*Alzheimer's Yes_____ No_____
***Angina Yes_____ No_____**
*Migraines Yes_____ No_____
***Epilepsy/Seizures Yes_____ No_____**
*Glaucoma Yes_____ No_____
***Renal Dialysis Yes_____ No_____**
*Thyroid Yes_____ No_____
***Snoring/ Sleep Apnea Yes_____ No_____**
*Do you use a CPAP? Yes_____ No_____
***Asthma Yes_____ No_____**
*Emphysema/
Respiratory Illnesses Yes_____ No_____
***Lung Disease Yes_____ No_____**
* Stroke Yes_____ No_____
***Heart Murmur Yes_____ No_____**
*Recurrent Illnesses Yes_____ No_____
Explain _____
***Defibrillator Yes_____ No_____**
*Abnormal Heart Condition Yes_____ No_____
Explain: _____
***Slow healing Yes_____ No_____**
*Diabetes Yes_____ No_____
***Rheumatic Fever Yes_____ No_____**
*Hypoglycemia Yes_____ No_____

***Anaphylaxis Yes_____ No_____**
* Fainting Spells/Dizziness Yes_____ No_____
***Liver Disease (including Jaundice) Yes_____ No_____**
*Hepatitis, any form Yes_____ No_____
Type _____
***Sexually Transmitted Disease Yes_____ No_____**
*HIV Positive/AIDS Related Complex Yes_____ No_____
***Blood Disease Yes_____ No_____**
*Kidney Disease Yes_____ No_____
***Previous Biopsies Yes_____ No_____**
*Cancer Yes_____ No_____
Type _____ Date_____
Chemo _____ Radiation_____
***High Cholesterol Yes_____ No_____**
*Pacemaker Yes_____ No_____
***Anemia Yes_____ No_____**
*Abnormal Blood Pressure Yes_____ No_____
High/Low, What is it usually? S_____/D_____
***Hemophilia Yes_____ No_____**
*Arthritis Yes_____ No_____
***Osteoporosis Yes_____ No_____**
*Joint Replacement Yes_____ No_____
Area and date of replacement:_____
***Abnormal bleeding Yes_____ No_____**

Do you have a medical condition that requires you to pre-medicate with antibiotics before dental treatment? Yes_____ No_____ Reason: _____

Are you allergic to:

Penicillin	Yes_____ No_____	Codeine	Yes_____ No_____
Sulfa	Yes_____ No_____	Tylenol/Acetaminophen	Yes_____ No_____
Latex	Yes_____ No_____	Advil/Ibuprofen	Yes_____ No_____
Clindamycin	Yes_____ No_____	Local Anesthetic	Yes_____ No_____

Please list other allergies (include drugs/medications, foods, seasonal, etc):

_____

Pharmacy Name: _____ Phone: _____

Health History Continue

List any medications you are currently taking:

1.) _____ 6.) _____
2.) _____ 7.) _____
3.) _____ 8.) _____
4.) _____ 9.) _____
5.) _____ 10.) _____

Have you ever taken Fosamax, Boniva, Actonel or any other medication containing bisphosphonates? Yes ____ No ____

Are you taking any Antacids? Yes ____ No ____

Are you taking Tagamet/Cimetidine? Yes ____ No ____ If yes, how often? _____

Are you taking any herbal supplements/medications? Yes _____ No _____

If yes, which ones? _____

Are you a smoker? Yes ____ No ____ If yes, how much per day? _____

Do you use controlled substances? Yes ____ No ____

Women: Are you pregnant? Yes ____ No ____

If yes, how many weeks? _____

Are you planning a pregnancy in the next 6 months? Yes ____ No ____

Are you nursing? Yes ____ No ____

_____ _____ _____

Patient Name (Please print) Patient/Guardian Signature Date

PREMIER DENTAL CENTER

Today's Date _____

USE OF PHOTOGRAPHS,VIDEOS, AND IMAGES

By initializing below, you acknowledge and understand that photographs,videos, and other images, such as x-rays, and other records may be created during my examination, treatment, and follow-up care. I give my permission for such items to be used for purposes of research, education, advertisement, or publication. Identifying information will be omitted. You also understand that you have the right to refuse to sign this acknowledgement. _____ (Initial)

CONSENT

By initialing below, you hereby authorize the doctor to take x-ray, photographs, or other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of patients' dental needs. I also authorize the doctor to perform any and all forms of treatment medication, and therapy that may be indicated in connection with the dental care of the patient. _____ (Initial)

NOTICE OF PRIVACY PRACTICES

By signing below, you acknowledge and understand that you have received and read a copy of the Notice of Privacy Practices._____ (Sign)

Would you like for anyone to have access to your account? Yes No

Name:_____ Relationship_____ Phone:_____

Name:_____ Relationship_____ Phone:_____

_____(Patient Signature)

INSURANCE FILING

By initialing below, you authorize the dentist to release any information including the diagnosis and the record of any treatment or examination rendered to my child or me during the period of such care to third party payers and/or health practitioners.I authorize and request my insurance copay to pay directly to the dentist or dental group insurance benefits otherwise payable to me.You also acknowledge and understand that you are ultimately responsible for payment in full on your account, not the insurance company. We do file dental insurance claims as a courtesy to our patients. You understand that we can only make **ESTIMATES** regarding your insurance benefits based on the information provided by you and the insurance company. In the event your insurance company does not pay as much as expected, you understand that the remaining balance is due and payable immediately by you. _____ (Initial)

FINANCIAL POLICY

Our office accepts: Cash, Check, Credit or Debit Card, Monthly payment options with Card Credit and Sunbit. Any balance not paid by your insurance company within 60 days after the date of service will be the responsibility of the patient. Some visits require an initial deposit of up to 20% in order to hold the preferred time. Any deposit paid will be credited toward your estimated portion on the date of service . Should you need to change a reservation, please allow our office 24 hours notice to avoid forfeiture of your reservation deposit. Any balance not paid or have prior arrangements made with the office will be subject to collections. _____ (Sign)

PREMIER
DENTAL CENTER

Notice of Privacy As a provider of dental services we are required, under the Health Insurance Portability and Accountability Act, to inform you of your rights to protect your personal health information. As a covered entity, we must inform all patients of their rights regardless of insurance coverage.

Our Duty To You: As your dental provider we will do everything within our control to maintain your records and information in a secure and private manner. We reserve the right to change our policies, but you will be informed of any changes in advance. We will only release information about you and your treatment under specific circumstances. These include, but are not limited to the following:

Treatment: We may use your information during the course of treatment. This includes releasing information to other dentists, physicians, other health care providers, lab technicians, and our staff. Our staff includes full and part time employees, as well as, temporary personnel.

Payment: We may disclose personal information about you and your treatment to third party carriers and payment processing entities. This includes insurance carriers, claims clearinghouses, collection agencies, and third party administrators such as employee medical reimbursement accounts.

Operations: We may use your personal information in the course of operations of our office. This may include quality assurance/quality improvement reviews, credentialing, training, and certification and accreditation activities.

Miscellaneous Uses: At certain times we may be required to use your information for other purposes than as described above. Examples of these uses include: appointment reminders (cards, voice messages, and letter), abuse/neglect, national security, immediate family and friends (only to the extent for use in healthcare operations or payment), schools (letter excusing absence due to dental treatment), education (use of information in presentations or lectures regarding specific treatment or procedure), advertising, and in some cases to law enforcement and court ordered releases (coroner, worker's compensation, automobile policies, and life insurance policies).

Restrictions: You have the right to request restrictions or disclosure of usage. We are not required to accept these restrictions but we will make a note of the request and honor that request if applicable.

Access: You have the right to access your personal health information. A request for access must be made in writing. You may speak to our privacy officer to schedule an appointment to view your information. You may also request a copy of your personal health information. We will charge you a fee for the copies as set by the Tennessee Board of Dentistry.

Amendment: You have the right to request that we amend your personal health information. Your request must be in writing and explain what should be amended and the rationale for such request. We have the right to deny this request if we feel that it would render your information inaccurate. We will inform you of the decision to amend your information.

Disclosures: You have the right to request a list of the times and entities to whom we have disclosed your personal health information. These disclosures are only for instances other than treatment, payment or operations. This disclosure will be given free on an annual basis if requested. We reserve the right to charge for this if requested more than once in a 12 month period.

Complaints: Please contact our privacy officer for any questions or complaints. If you feel that we have violated your privacy you can submit a written complaint to the U.S. Department of Health and Human services. We can provide you with the address upon request.