We are pleased to welcome you to our office. Please take a few minutes to fill out your patient information forms as completely as you can. We'd be glad to help if you have any questions.

Patient Information

Patient Name: _____ Preferred Name: _____
Last First MI

Birthdate: _____ SSN: _____ Home Phone: _____ Cell Phone: _____

Gender: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married E-Mail: _____

Would you like to receive text message or e-mails regarding your dental appointments? ☐ Yes ☐ No

Address: _____ How did you hear about us? Please be specific:

City: _____ State: _____ Zip: _____ _____

If the patient is under 18 years old, please complete the following information:

Guarantor Name: _____ Relationship to patient: _____
Last First MI

Birthdate: _____ SSN: _____ Home Phone: _____ Cell Phone: _____

Gender: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married E-Mail: _____

Emergency Contact

Name: _____ Relation: _____ Phone: _____
Last First

Insurance Policy

Subscriber Name: _____ Relationship to subscriber: ☐ Self ☐ Spouse ☐ Child

Insurance Company: _____ Subscriber ID: _____ Subscriber DOB: _____

Group Name: _____Group #: _____ Employer: _____

If you have coverage under more than one insurance company, please fill out the following information:

Subscriber Name: _____ Relationship to subscriber: ☐ Self ☐ Spouse ☐ Child

Insurance Company: _____ Subscriber ID: _____ Subscriber DOB: _____

Group Name: _____Group #: _____ Employer: _____

Authorization and Financial Agreement

I consent to the diagnostic procedures and dental treatment performed by my dentist that is necessary for proper dental care, and to the release of information concerning my (or my child's) health care, advice, and treatment to another dentist, or for evaluating and administering any claims for insurance benefits. I consent to the direct payment of my insurance benefits to dentist or dental group and understand that my insurance benefits may pay less than the actual bill for services and that I am responsible for any account balance. Patients are expected to pay for services at the time they are rendered. Patients with dental insurance are expected to pay for their estimated co-pay and deductible at the time of service. We accept cash, check, and credit card payments. Monthly statements are sent to all patients with an outstanding balance.

I certify that the above information is complete and correct to the best of my knowledge.

Patient or Guardian's Signature: _____ Date: _____

Premier Dental Group Hi Inc

Medical History

Patient Name:	Chart#:	Account# :
Medical History as on :		

Patient Medical Information

Allergic To

- ☐ Y ☐ N No Known Allergies
- ☐ Y ☐ N Amoxicillin
- ☐ Y ☐ N Aspirin
- ☐ Y ☐ N Barbiturates / Sleeping Pills
- ☐ Y ☐ N Codeine
- ☐ Y ☐ N Erythromycin
- ☐ Y ☐ N Iodine
- ☐ Y ☐ N Latex Rubber
- ☐ Y ☐ N Local Anesthetics
- ☐ Y ☐ N Metals
- ☐ Y ☐ N No Epinephrine
- ☐ Y ☐ N Penicillin
- ☐ Y ☐ N Prior Hepatitis
- ☐ Y ☐ N Sulfa Drugs
- ☐ Y ☐ N Other Narcotics

Check, if applicable

- ☐ Y ☐ N No Change Since Last Recorded
- ☐ Y ☐ N No Known Concerns or Issues
- ☐ Y ☐ N Abnormal Bleeding
- ☐ Y ☐ N AIDS/HIV Infection
- ☐ Y ☐ N Alcohol/Drug Abuse
- ☐ Y ☐ N Angina
- ☐ Y ☐ N Anemia
- ☐ Y ☐ N Ankles Swell
- ☐ Y ☐ N Anorexia
- ☐ Y ☐ N Arteriosclerosis
- ☐ Y ☐ N Arthritis
- ☐ Y ☐ N Asthma
- ☐ Y ☐ N Autoimmune Disease
- ☐ Y ☐ N Bladder Trouble
- ☐ Y ☐ N Blood Clotting Problems
- ☐ Y ☐ N Blood Transfusion
- ☐ Y ☐ N Bulimia
- ☐ Y ☐ N Bronchitis
- ☐ Y ☐ N Cancer / Tumor or Growth
- ☐ Y ☐ N Cardiac Pacemaker
- ☐ Y ☐ N Cardiovascular Disease
- ☐ Y ☐ N Chemotherapy
- ☐ Y ☐ N Chest Pain Upon Exertion
- ☐ Y ☐ N Color Blindness
- ☐ Y ☐ N Congenital Heart Defect
- ☐ Y ☐ N Contact Lenses
- ☐ Y ☐ N Congestive Heart Failure
- ☐ Y ☐ N Damaged Heart Valve
- ☐ Y ☐ N Diabetes
- ☐ Y ☐ N Emphysema
- ☐ Y ☐ N Environmental Allergies
- ☐ Y ☐ N Epilepsy
- ☐ Y ☐ N Fainting Spells
- ☐ Y ☐ N Fever Blisters
- ☐ Y ☐ N Frequent Headaches
- ☐ Y ☐ N Frequently Dry Mouth / Sjogren
- ☐ Y ☐ N Gag Reflex
- ☐ Y ☐ N Gall Bladder Trouble
- ☐ Y ☐ N Hay Fever
- ☐ Y ☐ N Heart Attack
- ☐ Y ☐ N Heart Disease
- ☐ Y ☐ N Heart Murmur
- ☐ Y ☐ N Hepatitis
- ☐ Y ☐ N Herpes
- ☐ Y ☐ N High Blood Pressure
- ☐ Y ☐ N Hives
- ☐ Y ☐ N Jaundice
- ☐ Y ☐ N Joint Replacement
- ☐ Y ☐ N Kidney
- ☐ Y ☐ N Leukemia
- ☐ Y ☐ N Liver Disease
- ☐ Y ☐ N Low Blood Pressure
- ☐ Y ☐ N Lupus
- ☐ Y ☐ N Mental Health Problems
- ☐ Y ☐ N Mitral Valve Prolapse
- ☐ Y ☐ N Pacemaker
- ☐ Y ☐ N Persistent Diarrhea
- ☐ Y ☐ N Premedicate
- ☐ Y ☐ N Radiation Treatment
- ☐ Y ☐ N Rheumatic Fever
- ☐ Y ☐ N Rheumatic Heart Disease
- ☐ Y ☐ N Rheumatoid Arthritis
- ☐ Y ☐ N Seizures
- ☐ Y ☐ N Sexually Transmitted Disease
- ☐ Y ☐ N Shortness of Breath
- ☐ Y ☐ N Skin Rash
- ☐ Y ☐ N Sinus Trouble
- ☐ Y ☐ N Stomach Ulcers
- ☐ Y ☐ N Stroke
- ☐ Y ☐ N Thyroid Problems
- ☐ Y ☐ N Tuberculosis
- ☐ Y ☐ N Unusual Weight Loss
- ☐ Y ☐ N Urinate Frequently

Other

- ☐ Y ☐ N See Scanned Documents: Pt Note

Dental Questionnaire

Dental Questionnaire

Name of previous Dentist	
Phone	
Date of your last cleaning	
Last exam date	
Do your gums bleed while brushing or flossing ?	
Are your teeth sensitive to hot, cold or sweets ?	
Have you had any head, neck or jaw injuries ?	
Do you clench or grind your teeth ?	
Have you ever had orthodontic treatment ?	
If Yes, date of placement	
Do you wear dentures or partials ?	
If Yes, date of placement of dentures ?	

Are you having any specific problems with your teeth, gums, or mouth at this time ?	
Are you happy with your smile ?	
Additional Comments	
Any Disease, Condition or Problem not Listed ? Please list	

Medical Questionnaire

Emergency Contact	
Emergency contact name	
Emergency contact phone	
Emergency contact relationship to patient	
Medical Questionnaire	
Family Physician	
Phone	
Are you currently under care of a Physician ?	
If Yes, what is the condition being treated ?	
Have you had any serious illness, operation or been hospitalized within the past 5 years ?	
If Yes, what illness or problem ?	
Are you currently taking any medication ?	
If Yes, what ?	
Have you taken bisphosphonates (Fosamax, Boniva, Zometa, Actonel, Didronel, Aredia, Skelid, Reclast)	
Have you ever taken the diet control drug Fen-Phen ?	
Are you aware of having an allergic(or adverse)reaction to any substance or medication?	
If yes, please specify	
Do you use alcoholic beverages ?	
Do you smoke ?	
Women Only	
Are you pregnant?	
If Yes, what is your due date ?	
Are you currently nursing ?	
Do you have menstrual period problems ?	
Are you on hormone replacement therapy ?	
Are you on birth control pills / fertility drugs ?	
Additional Comments	
Any Disease, Condition or Problem not Listed ? Please list	

By signing below, I certify that all of the above information is true to the best of my knowledge.

Patient Signature

Date

Dentist Signature

Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have reviewed and understand this practices' Notice of Privacy Practices written in plain language. The notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practices legal duties with respect to my information.

I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices, and to make changes regarding all protected health information resident at, or controlled by, this practice. If changes to the policy occur, this practice will provide me a revised Notice of Privacy Practices upon request.

_____

Patient's Name

_____ _____

Signature Date

_____

_____

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgement of receipt of our Notice of Privacy from this patient, but it could not be obtained because:

___ Individual refused to sign.

___ Communications barriers prohibit obtaining the acknowledgement.

___ An emergency situation prevented us from obtaining acknowledgement.

___ Other (please provide specific details)

Authorization for Release of Patient Information to Family or Friend

I,_____, authorize my information to be given to:
(patient name)

Name:_____ Relationship:_____

Name:_____ Relationship: _____

Name:_____ Relationship: _____

I understand that by signing this form only the person(s) designated above is/are allowed to obtain my information. I understand that the person(s) listed above will have availability to all my health information, appointment dates/times, office notes, and insurance information that Premier Dental Group HI have on file. I understand that this written authorization will remain in my permanent record and will not change at any time unless I issue a written consent to discontinue and/or change this authorization.

_____ _____
Patient Name (print) Date

_____
Signature of Patient