

# Premier Dental

## *Welcome to*

Thank you for choosing Premier Dental. Our goal is to provide you with the best possible dental care. To help us meet your dental needs, please fill out these forms. If you have any questions or need assistance, please ask – we will be happy to help.

### **PATIENT INFORMATION**

Last Name \_\_\_\_\_ First \_\_\_\_\_ Initial \_\_\_\_\_

I prefer to be called \_\_\_\_\_ Birth date \_\_\_\_\_ Today's Date \_\_\_\_\_

Minor \_\_\_\_\_ Single \_\_\_\_\_ Married \_\_\_\_\_ Widowed \_\_\_\_\_

Male Female \_\_\_\_\_ Social Security # \_\_\_\_\_

Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

When is the best time to call you? \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Employer Address \_\_\_\_\_

E-mail address \_\_\_\_\_

How did you hear about our office? Yellow Pages Website Word of Mouth Other: \_\_\_\_\_

Is there someone we may thank for referring you to us? Name \_\_\_\_\_

Nearest Relative: Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

### **PERSON RESPONSIBLE FOR THIS ACCOUNT**

Last Name \_\_\_\_\_ First \_\_\_\_\_ Initial \_\_\_\_\_

Address \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

City, State, Zip \_\_\_\_\_ Soc. Sec# \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Employer \_\_\_\_\_

Preferred Payment: Cash Check Credit Card I wish to discuss other financial options.

### **INSURANCE INFORMATION**

Policy Holder's Name \_\_\_\_\_

Policy Holder's Soc. Sec# \_\_\_\_\_

Policy Holder's Birth date \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Policy Holder's Employer \_\_\_\_\_

Insurance Company \_\_\_\_\_

Insurance Company Address \_\_\_\_\_

Group# \_\_\_\_\_ Employer/Cert# \_\_\_\_\_

Have you used this insurance at another dental office this year? \_\_\_\_\_ Deductible amt:\$ \_\_\_\_\_

***Please note the patient is responsible for the payment of charges not covered by the insurance, at the time of service.***

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**PATIENT INFORMATION FORM**

### MEDICAL INFORMATION

Do you have a personal physician? Yes No Name \_\_\_\_\_

Date of last visit \_\_\_\_\_ Your current physical health is: Good Fair Poor

Are you currently under the care of a physician? No Yes Please explain: \_\_\_\_\_

Are you taking any medication? Yes No Please list each one: \_\_\_\_\_

Have you ever had any of the following diseases or medical problems? (please circle each one)

Y N Heart Attack/Stroke	Y N Cancer Chemotherapy	Y N Heart Murmur
Y N Rheumatic Fever	Y N HIV+/AIDS	Y N Shingles
Y N Heart Surgery/Pacemaker	Y N Mitral Valve Prolapse	Y N Kidney Problems
Y N Artificial Bones/Joints	Y N Artificial Valves	Y N Venereal Disease
Y N High/Low Blood Pressure	Y N Fever Blisters	Y N Psychiatric

Problems

Y N Severe/Frequent Headaches	Y N Drug/Alcohol Abuse	Y N
Epilepsy/Seizures		
Y N Diabetes	Y N Tuberculosis	Y N Snoring/Apnea
Y N Congenital Heart Defect	Y N Anemia	Y N Radiation Treatment
Y N Asthma/Emphysema	Y N Hepatitis	Y N Glaucoma
Y N Blood Transfusion	Y N Hospitalized for any reason	Y N
Hemophilia/Abnormal Bleeding		

Please list any serious medical condition(s) that you have ever had: \_\_\_\_\_

Are you allergic to any of the following?

Y N Penicillin	Y N Tetracycline	Y N Latex	Y N Aspirin
Y N Codeine	Y N Erythromycin	Y N Dental Anesthetics	
Y N Other: _____			

For women: Are you pregnant? \_\_Week \_\_\_\_\_ Are you taking birth control pills? \_\_\_\_\_ Are you nursing? \_\_\_\_\_

### DENTAL INFORMATION

Why have you come to visit the dentist today? \_\_\_\_\_

Last dental visit? \_\_\_\_\_ Purpose: \_\_\_\_\_ Last complete exam? \_\_\_\_\_

Has fear of discomfort kept you from regular visits? Yes No

How would you describe your present dental health? Good Fair Poor

If you could wave a magic wand and change anything about your smile, what would it be? \_\_\_\_\_

How many: times a week do you floss? \_\_times a day do you brush? \_\_\_\_\_ Brand toothpaste? \_\_\_\_\_

Type of bristles? Hard Medium Soft Do your gums ever bleed? \_\_\_\_\_

Have you had any unusual or adverse effects from previous dental treatment? Yes No

If so, please describe: \_\_\_\_\_

Is your drinking water fluoridated? Yes No Do you use supplemental fluoride (gel, rinse or tablets)? \_\_\_\_\_

Would you like information on: Braces Non-surgical snoring treatment Whitening  
Sealants Cosmetic changes to improve my smile Other \_\_\_\_\_

◆ I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or other health practitioners.

◆ I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me.

◆I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependants.

X

Signature of patient or parent if minor

Date

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**DENTAL AND MEDICAL HISTORIES**



## ***Your Investment in Dental Care***

### **Insurance:**

We are happy to file insurance claims for you, and we will do our best to help you receive the maximum benefit your insurance contract allows. If you choose to have us help file your insurance claims, it is important for you to understand the following:

- Please bring proof of insurance to your first visit (insurance card).
- Please be familiar with your benefits package.
- Be prepared to pay your portion and any deductibles at each visit.
- Expect to receive monthly statements from Premier Dental until the claim is paid or denied. After 60 days, any outstanding insurance balances will be due in full by you, the patient. This includes any amounts which your company may label as "above reasonable and customary". (They may choose an arbitrary amount, which is frequently below even the *average* dental practice. We do not set our fees based on insurance contracts.)
- Please remember – it is up to you, the patient, to maintain responsibility for your insurance benefits. We file claims for you only as a service to you. All problems with insurance are between the patient and the insurance carrier.

***You, the patient, are responsible for all fees incurred***, whether you have insurance or worker's compensation benefits, or not. You are responsible for any

and all fees incurred while collecting unpaid balances. An 18% finance charge will be applied to your account once it becomes 90 days overdue.

**Courtesy Discount:**

For treatment plans over \$500, we offer a 5% courtesy discount if the entire treatment plan, including expected insurance amounts, is paid in full before treatment begins.

**Financing and Payment Options:**

We offer financing through separate companies (one is interest-free for up to 6 months) if the patient qualifies. Please talk with us prior to treatment to arrange this special financing. We also accept cash, check, VISA, MasterCard, and Discover. (A \$20 service charge will be assessed for returned checks.)

I have read and understand my financial responsibilities:

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Date

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Signature

# Premier Dental

***We Welcome You to Premier Dental!*** We want to ensure that your visit with us is the easiest, most enjoyable experience you have ever had in a dental office. One of the ways we do this, is by having you complete the enclosed paperwork at a time convenient for you, and then bring it with you to your first visit. We would also like to acquaint you with some of the services we provide:

***Comfortable Care:*** We know this is a high priority to you and we make it ours also. We pride ourselves on state-of-the-art dentistry delivered by a gentle, caring doctor and staff. We have nitrous oxide (“laughing gas”), relaxation music and movies available for you.

***Many Services – One Location:*** Since our dentist is skilled and experienced in so many areas, you can enjoy the convenience of having your dental needs cared for by the doctor and staff you know and trust, in the same familiar office – rather than being referred elsewhere.

**General Dentistry:** Our services include crowns, root canals, extractions, sealants, as well as an extensive array of others. Our dental team is your ally in maintaining healthy teeth and gums.

**Cosmetic Procedures:** Whitening, veneers, and tooth-colored fillings (mercury free) can make a significant change in appearance. Let us help you discover the magic of a beautiful smile!

**Orthodontics:** Improving function and appearance, braces can align teeth, correct bite problems, and improve facial profile. Orthodontic appliances can help alleviate clenching, grinding, thumb-sucking – and resulting dental problems.

**Care for Your Whole Family:** Although you will find our office “kid friendly” we also easily accommodate the special needs an older adult may have. Since our chairs sit upright (except during a dental procedure) unlike the old-fashioned ones that constantly recline, they are more comfortable and easier for everyone to get in and out – especially from a wheelchair.

**Convenience:** We will happily file your insurance for you. For the portion that is your responsibility, we accept major credit cards, checks, or cash. For more extensive needs, we also offer a financing alternative if arrangements are made prior to treatment.

I look forward to meeting you. I consider it a privilege to provide for your dental wants and needs, and join my staff in welcoming you to our “family” of wonderful patients at Premier Dental.

Scot M. Olson, DMD