

New Patient Paperwork



E-mail: _____ Today's Date: _____

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Preferred Name :

Name:			Home Phone: <i>Include area code</i>		Cell Phone: <i>Include area code</i>	
_____ Last	_____ First	_____ Middle	() ()		() ()	
Address:			City:		State: Zip:	
_____ Mailing address						
Occupation:			Height: Weight:		Date of birth: Sex: M F	
SS# or Patient ID:			Emergency Contact:		Relationship:	
					Home Phone: Cell Phone: () () () () <i>Include area codes</i>	

If you are completing this form for another person, what is your relationship to that person?

Your Name _____ Relationship _____

Do you have any of the following diseases or problems: **(Check DK if you Don't Know the answer to the question)** **Yes No DK**

Active Tuberculosis.....

Persistent cough greater than a 3 week duration.....

Cough that produces blood.....

Been exposed to anyone with tuberculosis.....

If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.

Dental Information For the following questions, please mark (X) your responses to the following questions.

	Yes	No	DK		Yes	No	DK
Do your gums bleed when you brush or floss?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you participate in active recreational activities?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are your teeth sensitive to cold, hot, sweets or pressure?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had a serious injury to your head or mouth?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does food or floss catch between your teeth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	How do you feel about your smile?	_____		
Is your mouth dry?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	What is the reason for your dental visit today?	_____		
Have you had any periodontal (gum) treatments?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Date of last dental x-rays:	_____		
Have you ever had orthodontic (braces) treatment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Date of your last dental exam: _____			
Have you had any problems associated with previous dental treatment?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	What was done at that time?	_____		
Is your home water supply fluoridated?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	How did you hear about us?			
Do you drink bottled or filtered water?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/> Social Media (Facebook, Google)			
If yes, how often? Circle one: DAILY / WEEKLY / OCCASIONALLY				<input type="radio"/> Radio Ad			
Are you currently experiencing dental pain or discomfort?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/> Billboard			
Do you have earaches or neck pains?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/> TV Ad			
Do you have any clicking, popping or discomfort in the jaw?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/> Patient/Family Member: _____			
Do you brux or grind your teeth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/> PDC Employee: _____			
Do you have sores or ulcers in your mouth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/> Doctor Referral: _____			
Do you wear dentures or partials?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				

Medical Information Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

	Yes	No	DK		Yes	No	DK
Are you now under the care of a physician?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you had a serious illness, operation or been hospitalized in the past 5 years?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physician Name: _____ Phone: <i>Include area code</i> ()				If yes, what was the illness or problem?	_____		
Address/City/State/Zip: _____				Are you taking or have you recently taken any prescription or over the counter medicine(s)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you in good health?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If so, please list all, including vitamins, natural or herbal preparations and/or diet supplements:	_____		
Has there been any change in your general health within the past year?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____			
If yes, what condition is being treated?				_____			
Date of last physical exam:				_____			

Medical Information Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

(Check DK if you Don't Know the answer to the question)			Yes No DK				Yes No DK				
Do you wear contact lenses?			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you use controlled substances (drugs)?.....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you use tobacco (smoking, snuff, chew, bidis)?			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Date: _____ If yes, have you had any complications? _____						If so, how interested are you in stopping? (Circle one) VERY / SOMEWHAT / NOT INTERESTED					
Are you taking any medications for osteoporosis, bone loss or Paget's disease? If so please list: _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you drink alcoholic beverages?			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If yes, how much alcohol did you drink in the last 24 hours? _____					
Date Treatment began: _____						If yes, how much do you typically drink in a week? _____					
Allergies - Are you allergic to or have you had a reaction to: To all yes responses, specify type of reaction.			Yes	No	DK				Yes	No	DK
Local anesthetics _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Metals _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Aspirin _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Latex (rubber) _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Penicillin or other antibiotics _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Iodine _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Barbiturates, sedatives, or sleeping pills _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hay fever/seasonal _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sulfa drugs _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Animals _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Codeine or other narcotics _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Food _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.											
			Yes	No	DK				Yes	No	DK
Artificial (prosthetic) heart valve			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Autoimmune disease			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Previous infective endocarditis			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid arthritis			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Damaged valves in transplanted heart			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Systemic lupus erythematosus.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Congenital heart disease (CHD)						Asthma			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Unrepaired, cyanotic CHD			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bronchitis			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Repaired (completely) in last 6 months			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Repaired CHD with residual defects			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sinus trouble			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
						Tuberculosis			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.</i>						Cancer/Chemotherapy/ Radiation Treatment			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
						Chest pain upon exertion			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
						Chronic pain			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
						Diabetes Type I or II			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
						Eating disorder			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
						Malnutrition			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
						Gastrointestinal disease			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
						G.E. Reflux/persistent heartburn			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
						Ulcers			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
						Thyroid problems			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
						Stroke			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
						Glaucoma			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
						Hepatitis, jaundice or liver disease			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
						Epilepsy			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
						Fainting spells or seizures			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
						Neurological disorders			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
						If yes, specify: _____					
						Sleep disorder			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
						Mental health disorders			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
						Specify: _____					
						Recurrent Infections			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
						Type of infection: _____					
						Kidney problems			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
						Night sweats			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
						Osteoporosis			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
						Persistent swollen glands in neck			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
						Severe headaches/ migraines			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
						Severe or rapid weight loss			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
						Sexually transmitted disease			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
						Excessive urination			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?											
Name of physician or dentist making recommendation:									Phone:		
Do you have any disease, condition, or problem not listed above that you think I should know about?											
Please explain: _____											

NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.
 I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian: _____ Date: _____

FOR COMPLETION BY DENTIST

Comments: _____

Primary Dental Insurance

Subscriber Name: _____

Address: _____

City: _____ Zip: _____

SS#: _____ DOB: _____

Employer: _____

Insurance Co: _____

Secondary Dental Insurance

Subscriber Name: _____

Address: _____

City: _____ Zip: _____

SS#: _____ DOB: _____

Employer: _____

Insurance Co: _____

Person Responsible for Account if Other than Yourself

Name: _____ Relation: _____
Last First Middle

Social Security #: _____ - _____ - _____ Home Phone : (____) _____ - _____ Cell Phone (____) _____ - _____

CONSENT

The undersigned hereby authorizes doctor to take x-rays, models, 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 patient. I understand that all responsibility for dental services provided in this office for myself or my dependents are mine, due and payable at the time of services are rendered unless other arrangements have been made. By signing below, I understand and agree that in the event of default, I am legally liable for all costs of collection including collection fees, reasonable attorney fees, court costs, and all other costs related to the collection of this debt.

AUTHORIZATION AND RELEASE

I authorize the dentist to release any information including the diagnosis and the records 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 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 service.

PLEASE NOTE: PREMIER DENTAL CENTER IS NOT RESPONSIBLE FOR KNOWING YOUR INSURANCE BENEFITS IN DETAIL. OUR ESTIMATES ARE STRICTLY ESTIMATES!

Signature: _____ Date: _____
PATIENT OR RESPONSIBLE PARTY



COMMUNICATING WITH OUR OFFICE

As an added convenience for our patients, we now have text messaging and email capabilities when communicating with you about your family's care.

When communicating with our digital system, you can confirm most appointments with a click of a button! While changes to reservations, insurance updates, and clinical questions must be made with a team member directly, we are excited to offer this convenience to our valued dental family.

Please select all applicable options below:

_____ I agree to receive emails to the following email address: _____

_____ I agree to receive text messages to the following number: _____

At times, our office may take photos or videos of our team in action or simply having fun with our patients. These images may be used in our social media or other online platforms or may be posted throughout our office. Please select one of the options below relative to photos that may capture you or a family member:

_____ YES! I agree to allow photos of me or my family to be used by PDC

_____ NO! I do NOT agree to allow photos of me or my family to be used by PDC

Patient Name

Patient Signature

Date



Financial Policy

Thank you for choosing Premier Dental Center. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:

Our office accepts:

- Cash or check
- Credit or Debit Cards (Visa®, MasterCard®, American Express® or Discover Card®)
- Monthly payment options with Care Credit, Wells Fargo, and GreenSky credit cards.¹

We want our patients to get the most from their dental insurance. As a courtesy, we will work with your insurance company to maximize your benefits and limit your out of pocket costs. While we do our best to accurately estimate the benefits provided and the patient portion, your insurance carrier will ultimately determine what benefits are available. 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. We understand that life can be unpredictable at times and reservations may need to be changed. Should you need to change a reservation, please allow our office 24 hours notice to avoid forfeiture of your reservation deposit.

Fees for services rendered are ultimately the responsibility of the patient, regardless of insurance. Any balance not paid within 90 days after the date of service will incur a service charge of 1.5% per month (18% annually), unless a written financial arrangement is in place and satisfied.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

Patient, Parent or Guardian Signature

Date

Patient Name (Please Print)

¹CareCredit, Wells Fargo, and GreenSky are credit cards offered and are NOT an in-house credit program offered by Premier Dental Center or any other healthcare provider. You may apply for these healthcare credit cards and if approved, use it at Premier Dental Center's office. However the card agreement is between you and those lenders. Subject to credit approval.



Acknowledgement of Receipt Notice of Privacy Practices

By signing below, I acknowledge that I have received or reviewed the Notice of Privacy.

I hereby give my consent for the use of my personal health information for treatment, payment, operations and other uses as described in the privacy notice. I grant the right to my dentist to release my dental/medical histories and other information about my dental treatment to my insurance and/or other dental health professionals if needed. I agree with the terms of this notice and understand my rights under this notice.

I also authorize Premier Dental Center to release information to my spouse _____ or friend/family member _____ regarding my health, treatment, and financial account.

I also understand that I have the right not to sign this agreement.

Name (Please Print)

Signature

Relationship to Patient

Date

If we are unable to get your acknowledgement then our office will make notation to the reason why it was not obtained.

Reason why acknowledgement was not obtained:

Staff Name

Staff Signature

Date



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 do 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).

Your Rights

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