PATIENT INFORMATION

Thank you for choosing Premier for your dental needs. Please complete this required registration form. If you have any questions or concerns, please do not hesitate to ask our front desk for assistance.

NAME: ____________________ DATE: ___________ SS/HIC/Patient ID#: _____________________

ADDRESS: _______________________ CITY: ______________ STATE: ______ ZIP: ____________

GENDER: ☐ Male ☐ Female DOB: ___________ E-MAIL: ___________________________________

PHONE: (*Home*) ___________________ (*Cell*) ____________________ (*Work*) ____________________

PREFER TO RECEIVE CALLS AT: ☐ Home ☐ Cell ☐ Work ☐ No Preference

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Minor ☐ Separated ☐ Partnered

EMPLOYER / SCHOOL: _________________________ OCCUPATION: _________________________

WORK ADDRESS: _________________ CITY: ______________ STATE: ______ ZIP: ____________

SPOUSE / PARENT'S NAME: ______________________ EMPLOYER: _______________

WORK PHONE: ______________________

EMERGENCY CONTACT: _________________________ PHONE: ______________________________

WHOM MAY WE THANK FOR REFERRING YOU? ____

I ________________________ , agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist has a contractual agreement with my plan prohibiting all, or a portion, of such charges, to the extent permitted under applicable law. I authorize release of information relating to this claim. I also authorize payment of dental benefits, otherwise payable to me, to be paid directly to Premier General & Cosmetic Dentistry. ________ (Initial Here)

APPOINTMENT CANCELLATION POLICY

When you schedule an appointment with Premier General & Cosmetic Dentistry, we reserve that time to prepare in anticipation of serving you. If you should need to reschedule, we kindly request that you contact us by phone with advanced notice of 48 hours. We understand that conflicts arise, however, should you not show for your scheduled appointment, or cancel without adequate notice more than once, a $50 charge will be applied. Excessive failures to arrive for appointments may result in discontinuation of service.

________ (Initial Here)

PREMIER DENTISTRY

MEDICAL HISTORY

NAME OF PRIMARY CARE PROVIDER: ____

ADDRESS: ____________________________________ PHONE: _______________________

DATE OF LAST VISIT: _______________ HEALTH ISSUES IN THE LAST 5 YEARS?: ☐ Yes ☐ No

IF YES, PLEASE EXPLAIN: ____

____

CURRENT HEALTH CONDITION: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

(*Women*) ARE YOU CURRENTLY PREGNANT?: ☐ Yes ☐ No IF YES, HOW MANY MONTHS?: _______

PLEASE LIST ANY Rx OR MEDICATIONS: ____

____

PLEASE LIST VITMANS OR SUPPLEMENTS: ____

____

BLOOD PRESSURE (*IF YOU KNOW*): ________________

Please check if you are allergic to any of the following:

☐ Local Anesthetics ☐ Sulfa Drug ☐ Codeine/Other Narcotics ☐ Penicillin/Other Antibiotics ☐ Aspirin
☐ Latex ☐ Barbiturates, Sedatives, or Sleeping Pills ☐ Shellfish, Iodine, or Red Wine ☐ Other

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Do you have, or have had, any of the following:

☐ Aids/HIV Positive
☐ Alzheimer's Disease
☐ Anaphylaxis
☐ Arthritis/Gout
☐ Artificial Heart Valve
☐ Artificial Joint
☐ Asthma
☐ Blood Disease
☐ Blood Transfusion
☐ Breathing Problem
☐ Bruise Easily
☐ Cancer
☐ Chemotherapy
☐ Chest Pains
☐ Cold Sores/Fever Blisters
☐ Congenital Heart Disorder
☐ Convulsions
☐ Cortisone Medicine
☐ Diabetes
☐ Drug addiction
☐ Easily Winded
☐ Emphysema
☐ Epilepsy or Seizures
☐ Excessive Bleeding
☐ Excessive Thirst
☐ Fainting Spells/Dizziness
☐ Frequent Cough
☐ Frequent Diarrhea
☐ Frequent Headaches
☐ Genital Herpes
☐ Glaucoma
☐ Hay Fever
☐ Heart Attack/Failure
☐ Heart Murmur
☐ Heart Pace Maker
☐ Heart Trouble / Disease
☐ Hemophilia
☐ Hepatitis A
☐ Hepatitis B or C
☐ Herpes
☐ High Blood Pressure
☐ High Cholesterol
☐ Hives or Rash
☐ Hypoglycemia
☐ Irregular Heartbeat
☐ Kidney Problems
☐ Leukemia
☐ Liver Disease
☐ Low Blood Pressure
☐ Lung Disease
☐ Mitral Valve Prolapse
☐ Osteoporosis
☐ Pain in Jaw Joints
☐ Parathyroid Disease
☐ Psychiatric Care
☐ Radiation Treatments
☐ Recent Weight Loss
☐ Renal Dialysis
☐ Rheumatic Fever
☐ Rheumatism
☐ Scarlet Fever
☐ Shingles
☐ Sickle Cell Disease
☐ Sinus Trouble
☐ Spina Bifida
☐ Stomach/Intestinal Disease
☐ Stroke
☐ Swelling of Limbs
☐ Thyroid Disease
☐ Tonsillitis
☐ Tuberculosis
☐ Tumors or Growths
☐ Ulcers
☐ Venereal Disease
☐ Yellow Jaundice

Have you had any serious illnesses not listed on the previous page? If yes, please explain: ________________

____

____

DENTAL HISTORY

On a scale of 1 to 5 (With 1 representing low/poor and 5 representing high/excellent) please rate (circle):

How do you feel about your overall dental health?: 1 2 3 4 5

Over the last ten years, please rate how faithfully you have had your teeth cleaned.: 1 2 3 4 5

What is your level of sensitivity to dental procedures?: 1 2 3 4 5

How do you feel about your smile and the look of your teeth?: 1 2 3 4 5

Date of your last hygiene visit? ____________________

Are you interested in having regular hygiene cleanings? ☐ Yes ☐ No

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What is the main reason for your visit today?

☐ Tooth Pain ☐ Orthodontics (Braces) ☐ Sedation Dentistry ☐ Check-Up ☐ Cleaning ☐ Whitening
☐ Cosmetic Dentistry ☐ Sedation Dentistry ☐ Other ______________________

Have you ever been treated for TMJ? .... ☐ Yes ☐ No

Have you, or do you suffer from headaches? .... ☐ Yes ☐ No

Tension headaches? .... ☐ Yes ☐ No Migraine headaches?....... ☐ Yes ☐ No

Muscle Tenderness in jaw/teeth? .... ☐ Yes ☐ No

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I would like to learn more about:

☐ Orthodontics ☐ Whitening ☐ Cosmetic dentistry ☐ Sedation dentistry
☐ Implants ☐ Bridges ☐ Veneers ☐ Dentures
☐ Other ____

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