PATIENT HISTORY

In order to assure your child's safety, comfort and happiness during dental treatment, we need to obtain information from you. Please carefully and completely answer the questions below, prior to their appointment time.

THANK YOU!!

Patient Name: _____ Nickname if any: _____

Date of Birth: _____ Age: _____ Sex: M❍ F❍ Attends what school? _____

Brothers & Sisters: Name:_____ Age: _____

Name:_____ Age: _____

Pets (Kind & Name) _____ Interests/Hobbies _____

DENTAL HISTORY

Why did you make this appointment? _____

_____

How did you find our office?

Friend ❍ Sibling in office ❍

Phone Book ❍ Insurance ❍

Pediatrician ❍ Other _____

Is this your child's first dental visit? Yes ❍ No ❍

If not, date of last dental visit: _____

Approximate date of last dental x-rays: _____

Does your child have any dental issues: Yes ❍ No ❍

Has your child had an unpleasant dental experience? Yes ❍ No ❍

If yes, please explain: _____

Has your child had any major dental issues in the past? Yes ❍ No ❍

If yes, please explain: _____

Does your child receive fluoride? Yes ❍ No ❍

If yes, via water supply or daily supplement (circle one)

Does your child use toothpaste containing fluoride?

Use a fluoride rinse? Yes ❍ No ❍

Use fluoride mouthwash at home? Yes ❍ No ❍

Use dental floss? Yes ❍ No ❍

Use fluoride mouthwash in school? Yes ❍ No ❍

Has your child received fluoride treatments from a dentist? Yes ❍ No ❍

Indicate type of toothbrush used by child at home (circle one):

Soft Medium Hard Don't Know Electric

Have you been advised your child may have a "bite problem"? Yes ❍ No ❍

If so, please explain: _____

Does your child have any of the following oral habits:

Finger Sucking❍ Thumb Sucking❍ Nail Biting❍ Lip Sucking❍ Pacifier❍

Does your child have speech issue of which you are aware?

If so, who is treating this issue: Name _____ Contact # _____

MEDICAL HISTORY

PATIENT NAME: _____

Child's Pediatrician:
Name: _____
Address: _____
City, State, & Zip: _____
Telephone: _____

Does your child have regular medical examinations? Yes ❍ No ❍

Date of last visit to the pediatrician: _____

Does your child have emotional, mental or physical needs? Yes ❍ No ❍
If so, please describe: _____

Has your child had any of the following?

❍ Surgery ❍ Serious Illness
❍ Accident ❍ Hospitalized overnight
If so, please explain: _____
_____

Is your child currently under physician care?
Yes ❍ No ❍

Please list any current medications: _____
_____
_____

Has your child had a history of:

❑Anemia ❑Bone disorders
❑Heart trouble ❑Skin disorders
❑Heart murmurs ❑Ear infections
❑Rheumatic fever ❑ Tonsillitis
❑Diabetes ❑Brain injury
❑Kidney or liver disease ❑AIDS, HIV, ARC
❑Epilepsy/Seizers ❑Asthma
❑Tuberculosis ❑Hepatitis
❑Other: _____ ❑Profuse bleeding

Any future surgery or medical treatment planned at this time? Yes ❍ No ❍
If so, please explain: _____
_____
_____

Is your child allergic to any medications or food?
Yes ❍ No ❍
If so, please list: _____
_____
_____

Mother/Guardian:
Name: _____
Date of Birth: _____
Address: _____
City, State & Zip: _____
Home #: _____
Employer name: _____
Employer address: _____
City, State & Zip: _____
Work #: _____
Cell #: _____
Email: _____
Best # to be reached _____
Marital status: ❍Single ❍ Married ❍Separated ❍Divorced ❍Widowed

Father/Guardian:
Name: _____
Date of Birth: _____
Address: _____
City, State & Zip: _____
Home #: _____
Employer name: _____
Employer address: _____
City, State & Zip: _____
Work #: _____
Cell #: _____
Email: _____
Best # to be reached: _____
Marital status: ❍Single ❍ Married ❍Separated ❍Divorced ❍Widowed

Permission is hereby granted to the doctor to perform any necessary dental treatments for the child after the doctor's consultation with the parent or consenting adult. To the best of my knowledge, all information that has been provided is accurate.

Parent/Guardian Signature

Office Staff/Witness

Patient Name: _____ Date of Birth: _____

Name of Dental Insurance Company: _____

Name of Dental Insurance Subscriber: _____

Subscriber Social Security #: _____ Subscriber Date of Birth: _____

Subscriber ID #: _____ Group # _____

Relationship to Patient: _____

Subscriber's Employer: _____

Release of Information/Payment Authorization & Policy

I authorize the release of any dental information to Premier Dental Care to process insurance claims on my behalf. I authorize payment of dental benefits directly to Premier Dental Care for my child/dependent as listed above. I understand I am responsible for any deductibles, co-payments and/or amounts for services not covered by my insurance carrier.

Your dental insurance policy is an agreement between you and your insurance company. Please be aware that some and perhaps all of the service provided may not be covered by your carrier and therefore are your responsibility. If your insurance carrier has not paid your claim within 45 day, they automatically shall be billed to you. YOU AND NOT YOUR INSURANCE CARRIER ARE RESPONSIBLE FOR YOUR ACCOUNT. ALL APPLICABLE CO-PAYMENTS AND DEDUCTABLES ARE DUE AT THE TIME OF SERVICE.

Accounts are considered past due after 30 days. Past due accounts will be charged $5.00 finance per month. Checks returned by your bank are subject to a $25.00 returned item fee. If the undersigned defaults, the undersigned shall be responsible for the payment of all collection costs, attorney's fees and related court costs.

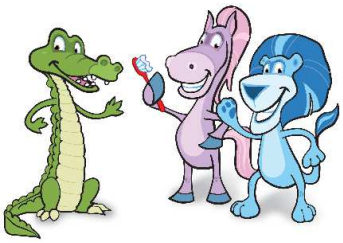
Kindly give 24 hour notice if unable to keep an appointment, otherwise a charge will be made for the time reserved.

_____ _____

Parent/Guardian Signature Date

_____ _____

Witness Date



Financial Policy

Thank you for choosing our practice for your dental care. Our team is committed to your overall health and the success of your treatment. Please understand that payment of your bill is considered a part of your commitment to treatment. Just as we are committed to providing you with the very best dentistry has to offer, we are also committed to making dentistry financially comfortable for you as well. Please take the time to read the following, initial each section, and sign & date the bottom of this form.

_____ We will review the estimated cost of treatment as well as review your payment options before treatment begins. We accept Cash, Checks, Visa, MasterCard, and Discover. We also work with CareCredit and Lending Club for patients that need to make monthly payments. **Please note that the processing fees associated with CareCredit and Lending Club are non-refundable.*

_____ As a courtesy, we will accept assignment of your insurance benefits and file your primary insurance claims. However, we do require payment in full of your co-pay and deductible at the time you receive treatment. It is important to understand that your insurance benefits are negotiated between your employer and your insurance company.

_____ As a result some, or perhaps all of the treatment provided may not be covered by your insurance. The cost of these procedures will be your responsibility. Please be aware that some insurance carriers will not allow you to assign your benefits to our office. In those cases, payment is due in full at the time of the visit and your insurance company will reimburse you directly.

_____ Due to the extensive amount of time our staff and doctors devote to preparing and reserving time for your treatment, reservations of 1 hour or longer will require a deposit of half of the treatment fee to make your reservation, which will include a $50.00 non-fundable deposit should the appointment be missed or cancelled with less than 48-hour's notice.

_____ Full payment is due at the time your receive treatment unless arrangements have been made ***prior*** to the start of any procedure.

_____ Patients are asked to confirm their appointments at least 48 hours in advance by directly contacting our office or by responding to our confirmation contact. Failing to confirm your appointment may result in the loss of your reservation and a possible charge for the time reserved.

_____ Appointments that are missed and/or cancelled with less than 48-hour's notice may require a future reservation fee prior to being rescheduled

_____ There will be a fee of $35.00 for any checks returned a Non-Sufficient Funds (NSF)

_____ Patient balances that go unpaid for 30 days or more may incur one or more of the following charges:

- Interest charge of 1.5% per month
- 18% APR collections fees (up to 25% of the full balance)
- Legal fees or Collection Services
-

I authorize payment to be made directly to Premier Dental Care by my insurance company. I accept full financial responsibility for all services performed in this office. I acknowledge that I have received and reviewed the Office Policies.

_____ _____

Patient Signature Date

Acknowledgement of Receipt

Notice of Privacy Practices
Our practice is committed to securing the privacy of your health information. Accordingly, we have posted our practice's Notice of Privacy Practices in the reception area. You are not required to read this notice. We would, however, like your acknowledgement that you have been notified that the notice is available for your review. You may request a paper copy of the notice by asking any of our team members.

Patient Name: _____

Signature:_____

Date:_____

An attempt was made to obtain written acknowledgement of receipt of our privacy practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented obtaining acknowledgement
- ☐ Other (please specify)_____
  _____
  _____

Team Member's Name: _____

Website and Social Media Release

Patient's Name (Please Print): _____

Premier Dental Care, on occasion, take photos and/or videos of patients to be used in our office, for our website (www.PremierDentalCare.net), Facebook, Twitter, Instagram, newsprint and/or related publications. This list is not inclusive, but serves to demonstrate situation is which patients may be photo'd or filmed.

Please Check One Below:

_____I give permission to Premier Dental Care to display my photo(s) or video(s) in association with Premier Dental Care events, functions and/or publications

_____I do NOT give permission to Premier Dental Care to display and/or post my photo(s) or video(s) in association with Premier Dental Care events.

_____ _____

Signature of Patient: Date

_____ _____

If patient is under 18 years of age – Signature of Patient's Parent/Legal Guardian Date

Date