Premiere Dentistry

Patient Information

First: _____ M.: _____ Last: _____

Preferred Name: _____ SS# ___-___-____ Birth Date: ___/___/___

Age_____ ☐ Male ☐ Female ☐ Single ☐ Married

Mailing Address: _____ City: _____ St.: ____ Zip: _____

Physical Address: _____ City: _____ St.: ____ Zip: _____

Home Phone: (____) ___-____ Cell Phone: (____) ___-____ Work Phone: (____) ___-____

Employer: _____ Occupation: _____

Emergency Contact

Name: _____ Relation: _____ Phone Number: (____) ___-____

If you are completing this form for another person what is your name and relationship to patient:

Name: _____ Relation: _____

Primary Insurance: ☐ Yes ☐ No **Secondary Insurance:** ☐ Yes ☐ No

Insurance Co. Name: _____ Insurance Co. Name: _____

Subscriber Name: _____ Subscriber Name: _____

Subscriber D.O.B: _____ Subscriber D.O.B: _____

ID#/SS#: _____ ID#/SS#: _____

Employer Name: _____ Employer Name: _____

Medicaid: ☐Yes ☐No ID#: _____

I authorize the Dentist to release any information acquired in the course of my treatment to third party payers and/or health practitioners. I authorize and hereby request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me. I understand that my dental carrier may pay less than my actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or on behalf of my dependents. I understand my account is payable within 30 days or a finance charge of 1.5% will be charged on the unpaid balance

Please initial and date after reading above: Initial: _____ Date: _____

Dental Information:	Yes	No		Yes	No
Do your gums bleed when you floss?	☐	☐	Do you have any discomfort in the jaw/ear area?	☐	☐
Are your teeth sensitive?	☐	☐	Do you grind your teeth?	☐	☐
Do you suffer from dry mouth?	☐	☐	Do you have sores or ulcers in your mouth?	☐	☐
Do you wear dentures or partials?	☐	☐	Is your home water supply fluoridated?	☐	☐
Are you currently experiencing discomfort?	☐	☐	Do you snore?	☐	☐

Other: _____

Health History

(WOMEN) Are you pregnant? ☐ Yes ☐ No
Due Date? _____
Are you takine birth control? ☐ Yes ☐ No

Are you currently taking any medications? ☐ Yes ☐ No

Please List: _____

_____

_____

_____

_____

Have you had any serious illnesses or operations?
☐ Yes ☐ No If so please list: _____

_____

Have you had an orthopedic total joint replacement?
☐ Yes ☐ No Date? _____ Surgeon: _____

Are you taking or scheduled to take any blood thinners?
☐ Yes ☐ No If yes, reason: _____

Do you take or have you taken any osteoporosis meds?
☐ Yes ☐ No

Has a physician or previous dentist recommended that you take an antibiotic prior to dental treatment? ☐ Yes ☐ No

Allergies: ☐ No Known Allergies

☐ Penicillin ☐ Sulfa Drugs ☐ Codeine ☐ Aspirin ☐ Latex ☐ Iodine ☐ Other: _____

Please mark (X) your response if you have or had have any of the following:

☐ Anemia	☐ Cardio Vascular Disease	☐ Hepatitis: A B C D	☐ Seizures
☐ Arthritis	☐ Congenital Heart Disease	How long ago? _____	☐ Sinus Issues
☐ Artificial bones/joints	☐ Diabetes	☐ HIV/AIDS	☐ Stomach Issues
☐ Blood Disease	☐ Dizziness/Fainting	☐ Kidney Problems	☐ Stroke
☐ Blood Pressure	☐ Drug/Alcohol Abuse	☐ Mitral Valve Prolapse	☐ Tobacco use
☐ High ☐ Low	☐ Dry Socket	☐ Mental Disorder	Smoking/Snuff/Chew
☐ Blood Transfusions	☐ Epilepsy	Specify: _____	How long? _____
☐ Breathing Difficulties	☐ Reflux/Persistent Heartburn	☐ Osteoporosis	☐ Tuberculosis
Explain: _____	☐ Heart Attack	☐ Panic Attacks/Nervousness	How long ago? _____
☐ Cancer	☐ Heart Murmur/A-fib	☐ Radiation Treatment	☐ Venereal Disease
☐ Chemotherapy When? _____	☐ Heart Surgery	☐ Severe Headaches/Migraines	How long ago? _____

_____ _____

Patient signature or parent of minor **Date**

For Office use only:
DDS: _____ **Hyg/Ast:** _____

For yearly updates:
Changes: ☐ Yes ☐ No Initial: _____ Date: _____
Changes: ☐ Yes ☐ No Initial: _____ Date: _____

For office use only:
DDS: _____ **Hyg/Ast:** _____
DDS: _____ **Hyg/Ast:** _____