# 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: _____

2020.06

# Health History

**(WOMEN)** Are you pregnant? ☐ Yes ☐ No
Due Date? _____
Are you taking 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 | ☐ Heart Surgery | ☐ Severe Headaches/Migraines | How long ago? _____ |
| When? _____ | | | |

_____ _____

**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:** _____

2020.06