



Premier Dental Care



Please take a few minutes to answer the following questions so we can better assist you with your dental needs.

PATIENT INFORMATION

Date Soc. Sec. # Birthdate Name Last Name First Name Initial Address Home Phone City State Zip Sex: M F Minor Single Married Long Term Partner Divorced Widowed Separated Employer Business Phone Business Address Occupation Who should we thank for referring you? In case of emergency, who should we contact? Phone

PRIMARY DENTAL INSURANCE

Person Responsible for Account Last Name First Name Initial Relationship to Patient Birthdate Soc. Sec. # Address Home Phone City State Zip Responsible Party Employed By Business Phone Business Address Occupation Insurance Company Insurance Company Address Subscriber I.D. # Group #

ADDITIONAL INSURANCE

Insured Name Last Name First Name Initial Relationship to Patient Birthdate Soc. Sec. # Address Home Phone City State Zip Insured Employed By Business Phone Insurance Company Insurance Company Address Subscriber I.D. # Group #

Please complete reverse side



## DENTAL HISTORY

Former Dentist \_\_\_\_\_

Date of Last X-Rays \_\_\_\_\_

City, State \_\_\_\_\_

How Often Do You Floss? \_\_\_\_\_

Date of Last Dental Visit \_\_\_\_\_

How Often Do You Brush? \_\_\_\_\_

Please check all that apply:

- |  |  |  |
|--|--|--|
| Bad Breath..... <input type="checkbox"/>                 | Loose Teeth or Broken Fillings..... <input type="checkbox"/> | Sensitivity to Sweets ..... <input type="checkbox"/>             |
| Bleeding Gums ..... <input type="checkbox"/>             | Orthodontic Treatment ..... <input type="checkbox"/>         | Sensitivity When Biting ..... <input type="checkbox"/>           |
| Blisters on Lips or Mouth ..... <input type="checkbox"/> | Pain Around Ear ..... <input type="checkbox"/>               | Frequent Headaches ..... <input type="checkbox"/>                |
| Finger Nail Biting ..... <input type="checkbox"/>        | Periodontal Treatment ..... <input type="checkbox"/>         | Jaw, Head or Neck Injuries ..... <input type="checkbox"/>        |
| Grinding Teeth ..... <input type="checkbox"/>            | Sensitivity to Cold ..... <input type="checkbox"/>           | Jaw Difficulty: Clicking and/or Pain... <input type="checkbox"/> |
| Lip or Cheek Biting ..... <input type="checkbox"/>       | Sensitivity to Heat ..... <input type="checkbox"/>           | Tooth Pain ..... <input type="checkbox"/>                        |

## MEDICAL HISTORY

Physician's Name \_\_\_\_\_ Date of Last Visit \_\_\_\_\_

- |   | Yes                      | No                       |
|---|--------------------------|--------------------------|
| 1. Are you currently under medical treatment? .....             | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you ever had any serious illnesses or operations? ..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are you currently taking any medication? .....               | <input type="checkbox"/> | <input type="checkbox"/> |
| Please describe: _____  |                          |                          |
| 4. Do you smoke? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you use alcohol? .....                                    | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Do you use cocaine or other drugs? .....                     | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Do you wear contact lenses? .....                            | <input type="checkbox"/> | <input type="checkbox"/> |

8. Have you had any allergic reactions to the following:

- |   | Yes                      | No                       |
|---|--------------------------|--------------------------|
| Local Anesthetics (eg. novocaine) ..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Penicillin or other Antibiotics .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| Sulfa Drugs .....                       | <input type="checkbox"/> | <input type="checkbox"/> |
| Barbiturates (sleeping pills) .....     | <input type="checkbox"/> | <input type="checkbox"/> |
| Sedatives .....                         | <input type="checkbox"/> | <input type="checkbox"/> |
| Iodine .....                            | <input type="checkbox"/> | <input type="checkbox"/> |
| Aspirin .....                           | <input type="checkbox"/> | <input type="checkbox"/> |
| Other .....                             | <input type="checkbox"/> | <input type="checkbox"/> |

9. (Women Only) Are You:

- |                                   | Yes                      | No                       |
|-----------------------------------|--------------------------|--------------------------|
| Pregnant? .....                   | <input type="checkbox"/> | <input type="checkbox"/> |
| Nursing? .....                    | <input type="checkbox"/> | <input type="checkbox"/> |
| Taking birth control pills? ..... | <input type="checkbox"/> | <input type="checkbox"/> |

Please check all that apply:

- |  |                          |                             |                          |                                   |                          |
|--|--------------------------|-----------------------------|--------------------------|-----------------------------------|--------------------------|
| AIDS .....   | <input type="checkbox"/> | Emphysema .....             | <input type="checkbox"/> | Pacemaker.....                    | <input type="checkbox"/> |
| Anemia.....  | <input type="checkbox"/> | Epilepsy .....              | <input type="checkbox"/> | Psychiatric Care .....            | <input type="checkbox"/> |
| Arthritis, Rheumatism .....                            | <input type="checkbox"/> | Fainting or Dizziness ..... | <input type="checkbox"/> | Radiation Treatment.....          | <input type="checkbox"/> |
| Artificial Heart Valves .....                          | <input type="checkbox"/> | Glaucoma .....              | <input type="checkbox"/> | Respiratory Disease.....          | <input type="checkbox"/> |
| Artificial Joints .....                                | <input type="checkbox"/> | Headaches.....              | <input type="checkbox"/> | Rheumatic Fever .....             | <input type="checkbox"/> |
| Asthma .....   | <input type="checkbox"/> | Heart Murmur .....          | <input type="checkbox"/> | Scarlet Fever .....               | <input type="checkbox"/> |
| Back Problems .....                                    | <input type="checkbox"/> | Heart Problems.....         | <input type="checkbox"/> | Shortness of Breath .....         | <input type="checkbox"/> |
| Bleeding abnormally, with extractions or surgery ..... | <input type="checkbox"/> | Hepatitis-Type _____        | <input type="checkbox"/> | Sinus Trouble.....                | <input type="checkbox"/> |
| Blood Disease .....                                    | <input type="checkbox"/> | Herpes.....                 | <input type="checkbox"/> | Skin Rash .....                   | <input type="checkbox"/> |
| Cancer .....   | <input type="checkbox"/> | High Blood Pressure .....   | <input type="checkbox"/> | Stroke .....                      | <input type="checkbox"/> |
| Chemical Dependency .....                              | <input type="checkbox"/> | HIV Positive .....          | <input type="checkbox"/> | Swelling of Feet/Ankles.....      | <input type="checkbox"/> |
| Chemotherapy .....                                     | <input type="checkbox"/> | Jaundice .....              | <input type="checkbox"/> | Swollen Neck Glands.....          | <input type="checkbox"/> |
| Chronic Fatigue Syndrome .....                         | <input type="checkbox"/> | Jaw Pain .....              | <input type="checkbox"/> | Thyroid Problems.....             | <input type="checkbox"/> |
| Circulatory Problems .....                             | <input type="checkbox"/> | Latex Sensitivity .....     | <input type="checkbox"/> | Tonsillitis .....                 | <input type="checkbox"/> |
| Congenital Heart Lesions.....                          | <input type="checkbox"/> | Kidney Disease .....        | <input type="checkbox"/> | Tuberculosis.....                 | <input type="checkbox"/> |
| Cortisone Treatments .....                             | <input type="checkbox"/> | Liver Disease.....          | <input type="checkbox"/> | Tumor or growth on head/neck..... | <input type="checkbox"/> |
| Cough - persistent or bloody.....                      | <input type="checkbox"/> | Low Blood Pressure .....    | <input type="checkbox"/> | Ulcer.....                        | <input type="checkbox"/> |
| Diabetes.....  | <input type="checkbox"/> | Mitral Valve Prolapse.....  | <input type="checkbox"/> | Veneral Disease .....             | <input type="checkbox"/> |
|  |                          | Nervous Problems.....       | <input type="checkbox"/> |                                   |                          |

## ASSIGNMENT AND RELEASE

I hereby authorize payment directly to \_\_\_\_\_ for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

I authorize the above doctor and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party \_\_\_\_\_ Date \_\_\_\_\_