

Patient Account # _____

Premier Dental Care

Applied for Care Credit _____

Registration and Health History

Patient Information

Patient's Name: Last _____ First _____ MI _____

Address: Street _____ Apt# _____ City _____ State _____ Zip _____

Phone: Home: _____ - _____ - _____ Work: _____ - _____ - _____ Cell: _____ - _____ - _____ Alt: _____ - _____ - _____

Date of Birth: ____/____/____ Social Security #: _____ Sex: M F

Patient's Occupation: _____ Student Y or N Where? _____

Responsible Party (parent or legal guardian if patient is a minor)

Name: Last _____ First _____ MI _____ Relationship _____

Address: Street _____ Apt # _____ City _____ State _____ Zip _____

Phone: Home: _____ - _____ - _____ Work: _____ - _____ - _____ Cell: _____ - _____ - _____ Alt: _____ - _____ - _____

Responsible Party's Occupation: _____

Emergency Contacts

Name: Last _____ First _____ Phone #: _____ - _____ - _____ Relationship _____

Name: Last _____ First _____ Phone # _____ - _____ - _____ Relationship _____

Dental History

Reason For Today's Visit: _____ Former Dentist: _____

Last date of dental check up _____ Last date of cleaning: _____ Were X-Rays taken? _____

How often do you brush? _____ How often do you floss? _____

Are you happy with the appearance of your teeth? Y N

Are you interested in cosmetic dentistry? Y N

Are you nervous about Dental Treatment? Y N

Please circle the following conditions that apply to you:

- | | | | | | |
|--------------------------|----------------------|-------------------------|---------------------------|-------------|-----------------------|
| Bad Breath | Grinding Teeth | Sensitivity to Hot/Cold | Bleeding Gums | Loose Teeth | Sensitivity to Sweet |
| Broken Fillings | Clicking/Popping Jaw | Sensitivity when Biting | Food Collections in Teeth | | Periodontal Treatment |
| Sores or Growth in Mouth | | | | | |

Medical History

Physician: _____ Date of Last Visit: _____

Please list any Prescribed or Over the Counter Medicines you are taking: _____

Please list any Drug or Chemical Allergies: _____

Please circle the following conditions that apply to you:

- | | | | |
|-------------------------|----------------------|-----------------------|--------------------------|
| ADD/ ADHD | Circulatory Problems | Hemophilia | Scarlet Fever |
| AIDS | Cortisone Treatments | Hepatitis | Shortness of Breath |
| Alzheimer | Cough, Persistent | High Blood Pressure | Sickle Cell Anemia |
| Anemia | Cough up Blood | HIV | Skin Rash |
| Arthritis | Diabetes | Jaw Pain | Swelling: Ankle/ Feet |
| Artificial Heart Valves | Down Syndrome | Kidney Disease | Thyroid Problems |
| Artificial Joints | Epilepsy | Liver Disease | Tobacco Habit |
| Asthma | Fainting | Mitral Valve Prolapse | Stroke |
| Autism | Fever Blisters | Nervous Disorder | Tonsilitis |
| Back Problems | Glaucoma | Pacemaker | Tuberculosis |
| Blood Disease | Hay Fever | Psychiatric Care | Ulcer |
| Cancer | Headaches | Radiation Treatment | Venereal Disease |
| Chemical Dependency | Heart Murmur | Respiratory Disease | Others Not Listed: _____ |
| Chemotherapy | Heart Problems | Rheumatic Fever | |

Females: Are you Pregnant? Y N Are you Nursing? Y N Are you taking Birth Control Pills? Y N

AUTHORIZATION

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION TO THE BEST OF MY KNOWLEDGE. THE ABOVE QUESTIONS HAVE BEEN ACCURATELY ANSWERED. I UNDERSTAND QUESTIONS NOT ANSWERED OR INCORRECTLY ANSWERED CAN BE HAZARDOUS TO MY HEALTH.

Signature of Responsible Party: _____ Date: _____

Whom may we thank for referring you to our office? a patient, yellow pages, sunshine pages, employee. If a patient referred you to us, please write his/her full name and telephone#: _____

Premier Dental Care
5188 Highland Road
Baton Rouge, LA 70808
225-766-8107, Fax: 225-766-2382

To Patients of Premier Dental Care:

*We make every effort to schedule appointments that are the most convenient for you and fit your personal schedule. We reserve the necessary time needed for each patient to provide the best dental care possible.

*We value your time and attendance during all dental appointments. Please make every effort to keep all dental appointments. This will ensure your comfort and lessen the progression of dental disease. Missed appointments compromise your care as well as the practice. We have implemented a cancellation procedure for all of our patients.

*A **24 hour** cancellation notice is required. This allows other patients in need of dental care to be contacted and offered the available appointment time.

*Patients who do not show up, are late, or fail to give us 24 hour notice to cancel or reschedule may be assessed a \$50.00 fee for this inconvenience. In the event that you cannot be assessed the missed appointment fee, such as with Medicaid, then we reserve the right not to reappoint you. To avoid this missed appointment fee and reappointments, we ask that you fax or mail appropriated documents for your emergency cancellations to our office.

*If we are forced to take collection action, you are responsible for all court costs and collection fees, including attorney fees, to the extent applicable by law. When inquiring about payment arrangements, we have the right to inquire on your credit history, and previous dental providers.

*All patients under the age of 18 must have a responsible party at each appointment and they must stay in the office during the entire appointment. Treatment will not be done without a responsible party in the office.

Signature: _____

Date: _____

Signing this form helps us know that this issue has been communicated to you. We truly appreciate your cooperation and understanding.

Premier Dental Care

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Section A: Patient Giving Consent

Name (print): _____ Patient's Account #: _____

Social Security#: _____

Section B: To the Patient– Please read the following statements carefully.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practice as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting: Mrs. Victoria Carlson, Business Manager, 5188 Highland Rd., Baton Rouge, LA 70808.

Right to Revoke: you will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that *we may decline to treat you or to continue treating you if you revoke this Consent.*

Information to be Used or Disclosed to patient's care-giver, parents, spouse, relatives, _____:

Disclosing financial and accounting issues, protected dental/health information including history, scheduling and inquiries of a patient's appointments.

The information covered by this section authorizes disclosure to certain person(s) or organizations that wish to have access to your protected health information.

Persons Authorized to Use or Disclose Information for above mentioned records:

Name of Person or Organization (Print entire name)

Name of Person or Organization (Print entire name)

Expiration Date of Authorization: ____/____/20____

This authorization is effective unless revoke or terminated by the patient or the patient's personal representative.

Right to Terminate or Revoke Authorization: You may revoke or terminate this authorization by submitting a written revocation to Premier Dental Care. You should contact Premier Dental Care or the Business Manager, Victoria Carlson, to terminate this authorization.

Potential for Re-Disclosure: Information that is disclosed under this authorization may be protected under the federal privacy regulations.

SIGNATURE

I, _____, *have had full opportunity to read and consider the contents of this*
(Print Name of Patient)

Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____ (Print)

Relationship to Patient: _____ (Print)

Insurance and Medicaid Patients Only

1. I authorize the release of any information relating to my claim.
2. I understand that not all insurance companies send the insurance check to the dental provider, and in the event that the insurance check is submitted to myself or any of my dependents under my policy, I, the policy holder, will be liable for rendering the insurance check to Premier Dental Care.
3. I understand that if my insurance company does not pay as expected, or is not a covered procedure, I will be responsible for the remaining balance, due to the fact that verification of benefits DOES NOT GUARANTEE payment from the insurance company.
4. For insurance patients only: Your insurance company only pays a percentage of the fee, and this varies from plan to plan. Your dental insurance is not designed to pay the entire cost of your treatment, but it is intended to help cover a certain portion of the cost.

I have read and understand the above.

Signature _____ Date _____

Insurance Patients Only

(please print clearly)

Policy Holder's Name	Sex	DOB	S.S.#	Employer
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Dependent's Name	Sex	DOB	S.S.#	
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Insurance Company Name: _____

Address: _____

City, State Zip: _____

Phone#: _____