Patient Information

Name _____ Date of Birth _____/_____/_____ SS# _____/_____/_____ SEX M ☐ F ☐

Address _____ City _____ State_____ ZIP_____

Cell Phone _____ Home Phone _____ Email _____

Emergency Contact Person _____ Emergency Contact Number _____

Are You an Insurance PRIMARY Subscriber? YES ☐NO ☐ How did you hear about us? Friend/Family ☐Walk in ☐Internet ☐Other_____

Do you give us permission to communicate with you (appointments, etc) YES ☐NO ☐Other (please specify) _____

Medical History

Physicians Name _____ Phone _____ Date of last visit _____

Have you had any serious illnesses or operations? YES ☐NO ☐ If yes, please describe _____

Are you currently under physician care? YES ☐NO ☐ If yes, please describe _____

Have you ever had a blood transfusion YES ☐NO ☐ If yes, give approximate dates _____

Women: Are you pregnant? YES ☐NO ☐ Nursing YES ☐NO ☐ Taking Birth Control pills? YES ☐NO ☐

Check whether you have had any of the following:

❑	*AIDS/ HIV Positive*	❑	*Cough up blood*	❑	*Liver Disease*	❑	*Swelling of feet or ankles*
❑	*Anaphylaxis*	❑	*Diabetes*	❑	*Material allergies (latex, wool, metal, chemicals)*	❑	*Thyroid disease or malfunction*
❑	*Anemia*	❑	*Epilepsy*	❑	*Nervous problems*	❑	*Tobacco habit*
❑	*Arthritis, Rheumatism*	❑	*Fainting*	❑	*Pacemaker/Heart Surgery*	❑	*Tonsillitis*
❑	*Artificial joints*	❑	*Food allergies*	❑	*Psychiatric care*	❑	*Tuberculosis*
❑	*Asthma*	❑	*Glaucoma*	❑	*Rapid weight gain or loss*	❑	*Ulcer/Colitis*
❑	*Atopic (allergy prone)*	❑	*Headaches*	❑	*Radiation treatment*	❑	*Venereal disease*
❑	*Back problems*	❑	*Heart murmur*	❑	*Respiratory disease*	❑	*Other, please list below:*
❑	*Blood disease*	❑	*Heart problems*	❑	*Rheumatic/Scarlet fever*		
❑	*Cancer*	❑	*Hemophilia/ Abnormal bleeding*	❑	*Shingles*		
❑	*Chemical dependency or illicit drug use*	❑	*Herpes*	❑	*Shortness of breath*		
❑	*Chemotherapy*	❑	*Hepatitis*	❑	*Skin rash*		
❑	*Circulatory problems*	❑	*High blood pressure*	❑	*Spina Bifida*		
❑	*Cortisone Treatments*	❑	*Jaw pain*	❑	*Stroke*		
❑	*Cough, persistent*	❑	*Kidney disease or malfunction*	❑	*Surgical implant*		

Reviewed by

*Dr.:*_____

Dental History

1. Do your gums bleed while brushing or flossing? YES ☐ NO ☐

2. Are your teeth sensitive to hot or cold liquid/foods? YES ☐ NO ☐

3. Are your teeth sensitive to sweet or sour liquids/foods? YES ☐ NO ☐

4. Do you feel pain to any of your teeth? YES ☐ NO ☐

5. Do you have any sores or lumps in or near your mouth? YES ☐ NO ☐

6. Do you have frequent headaches? YES ☐ NO ☐

7. Do you clench or grind your teeth? YES ☐ NO ☐

8. Do you bite your lips or cheeks frequently? YES ☐ NO ☐

9. Have you had any head, neck or jaw injuries? YES ☐ NO ☐

10. Have you ever had any instructions on the care of your gums? YES ☐ NO ☐

11. Have you ever had instructions on the correct method of brushing your teeth? YES ☐NO ☐

12. Have you had any orthodontic treatment? YES ☐NO ☐

13. Have you ever had any difficult extractions in the past? YES ☐NO ☐

14. Have you ever had any prolonged bleeding following extractions? YES ☐NO ☐

15. Have you ever experienced any of the following problems in your jaw?

- Clicking? YES ☐NO ☐
- Pain? (joint, ear, side or face) YES ☐NO ☐
- Difficulty in opening or closing? YES ☐NO ☐
- Difficulty in chewing? YES ☐NO ☐

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 that not providing information can be **dangerous** to my health.*

*SIGNATURE*_____ *DATE* _____/_____/_____

PRIME CHOICE DENTAL

AKNOWLEDGMENT OF NOTICE OF PRIVACY ACT OF PRACTICES

Prime Choice Dental – Dental Medicine Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. We will not disclose your health information other than with your written authorization. You may revoke that authorization in writing at any time.

BY SIGNING THIS FORM BELOW, I AKNOWLEDGE THE RECEIPT OF THE NOTICE OF PRIVACY ACT OF PRACTICES.

SIGNATURE X_____

WRITTEN FINANACIAL POLICY

Thank you for choosing **Prime Choice Dental**. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:

- Credit card: you can choose from: Visa, MasterCard, American Express, Discover Card
- Cash: we will gladly offer you a discount for all-cash payments
- NO INTEREST[1] Payment Plans[2] from Care Credit *(inquire within!)
  *Allows you to pay over time with no interest
  *Convenient, low monthly payment plans
  *No annual fees or pre-payment penalties

Please note:

- Prime Choice Dental requires payment prior to the completion of your treatment. If you choose to discontinue care before treatment is complete, your refund will be determined upon review of your case. For plans requiring multiple appointments, alternative payment arrangements may be provided. For larger, more comprehensive treatment plans of $2000 or more, a $500 OR 50% deposit is required to secure your initial treatment appointment.
- For patients with dental insurance, we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment[3].
- Your appointment slot is reserved just for you. As a courtesy to our dental staff, as well as to other patients, please do kindly notify us in advance if you are unable to make it. **A fee of $40 will be charged for patients who miss their scheduled appointments without at least a 24 hour cancelation request[4].**

If you have any questions, please do not hesitate to ask. We are here to help you get the best dental care possible.

Patient, Parent, or Guardian

Signature_____Date_____

[1] If paid within the promotional period. Otherwise, interest assessed from purchase date. Minimum monthly payment required.

[2] Subject to credit approval

[3]However, if we do not receive payment from your insurance carrier within 90 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.

[4]Apart from emergency circumstances.

PCD
PRIME CHOICE DENTAL