For internal use only
Dr________

Thank you for choosing our office to assist you with your dental needs!
Please fill out the information below as best you can, and please provide your signature on both sides.

Patient Information

First Name________________________________ Last Name __________________________________ MI _____ Date of Birth _____/______/_________

SS# ______/______/_________ SEX M ☐ F ☐ If minor, name of legal guardian____

Address______ ____ City _________________________ State___________ ZIP________________

Cell Phone ______________________________ Home Phone _______________________ Email ____

Emergency Contact Person ____ Emergency Contact Number _______________________________

Do you have dental insurance? ______________________________ Whom may we thank for referring you?_______________ __________________

Preferred method of contact Call ☐ Text ☐ Other (please specify) _____________________________

Medical History

✓ **Check only if you have (or had) any of the following:**

- ❑ AIDS/ HIV Positive
- ❑ Anemia
- ❑ Arthritis/Rheumatism
- ❑ Artificial joints
- ❑ Asthma
- ❑ Atopic (allergy prone)
- ❑ Back problems
- ❑ Blood disease
- ❑ Blood transfusions ____________________
- ❑ Cancer ____________________
- ❑ Chemical dependency/ illicit drug use
- ❑ Chemotherapy ____________________
- ❑ Circulatory problems
- ❑ Cough, persistent
- ❑ Cough up blood
- ❑ Diabetes (I/II)
- ❑ Epilepsy
- ❑ Food allergies
- ❑ Glaucoma
- ❑ Headaches
- ❑ Heart murmur
- ❑ Heart problems
- ❑ Hemophilia/ Abnormal bleeding
- ❑ Herpes
- ❑ Hepatitis (A/B/C)
- ❑ High blood pressure
- ❑ Kidney disease or malfunction
- ❑ Liver disease
- ❑ Mitral Valve Prolapse
- ❑ Material allergies (latex, wool, metal, chemicals)
- ❑ Nervous problems
- ❑ Pacemaker/Heart Surgery
- ❑ Psychiatric care
- ❑ Rapid weight gain or loss
- ❑ Radiation treatment ___________________
- ❑ Respiratory disease
- ❑ Rheumatic/Scarlet fever
- ❑ Serious illnesses or Operations ___________________
- ❑ Shingles
- ❑ Shortness of breath
- ❑ Skin rash
- ❑ Spina Bifida
- ❑ Stroke ____________________
- ❑ Surgical implant ____________________
- ❑ Swelling of feet or ankles
- ❑ Thyroid disease or malfunction
- ❑ Tobacco habit (packs per week) _________
- ❑ Tonsillitis
- ❑ Tuberculosis
- ❑ Ulcer/Colitis
- ❑ Venereal disease
- ❑ Other (please list anywhere below)

Are you allergic or had any adverse reaction to any of the following?

- ❑ Penicillin
- ❑ Local anesthetics
- ❑ Codeine or other narcotics

Women:

- ❑ Pregnant or planning on becoming to be pregnant
- ❑ Nursing
- ❑ Taking birth control or hormone treatments?

Primary Doctor Name__________________________

Phone _____________________________

Are you taking any of the following medications?

Please provide us with the list of all of your medications, if possible, so that we can better treat you:

- ❑ Aspirin
- ❑ Anticoagulants (blood thinners e.g Coumadin)
- ❑ Other: _______________________
- ❑ High blood pressure medicine
- ❑ Antidepressants or tranquilizers
- ❑ Insulin or other diabetic medicine
- ❑ Nitroglycerin
- ❑ Cortisone or other steroids

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 ☐

Signature__________________________________ **Date** _____/_____/______

AKNOWLEDGMENT OF NOTICE OF PRIVACY ACT OF PRACTICES

Prime Time 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 Financial Policy

Thank you for choosing **Prime Time 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 Time 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 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.