PREMIER
DENTAL PARTNERS

Name:_____
Date of Birth:_____
Sex: Male Female
Height:_____ Weight:_____
Are you currently in good health: Y N
Are you currently under the care of a doctor for a medical condition? If so, please list the conditions:

_____
_____

Doctors name, specialty, and telephone number:

_____
_____

Date of you last physical exam?_____

Have you been hospitalized or had surgery in the last 10 years? Is so, please explain:

_____
_____

What medications do you currently take on a regular basis (prescriptions and dietary supplements)?

_____
_____
_____

Do you have Latex Allergy? Y N

Are you allergic to any Medications? Y N

If so, please explain:

_____

Do you use tobacco? Y N (smoking, chew)

Packs/day_____ Number of years_____

On average, how many alcoholic beverages do you consume on a weekly basis? _____

Do you have any of the conditions listed below?

Heart disease (heart attack, murmur, irregular heart rate, chest pain, coronary artery disease, stents in the heart, pacemaker)	Y N
High blood pressure	Y N
Stroke	Y N
Respiratory disease (asthma, COPD, emphysema, bronchitis)	Y N
Epilepsy or seizures	Y N
Fainting or dizziness	Y N
Bleeding or blood disorders	Y N
Kidney disease	Y N
Liver disease (Hepatitis A, B, C)	Y N
HIV/ AIDS	Y N
Diabetes	Y N
Thyroid disease	Y N
Arthritis	Y N
Gastrointestinal disease (GERD, ulcers, celiac, Crohn's, ulcerative colitis)	Y N
Glaucoma	Y N
Osteoporosis	Y N
Implants or joint replacement	Y N
Injuries or tumors of the face or jaws	Y N
Cancer	Y N
Radiation therapy	Y N
Chemotherapy	Y N
Sinus or nasal problems	Y N
Sleep apnea	Y N
Organ transplant	Y N
Psychiatric (Depression, anxiety, schizophrenia)	Y N
Drug or alcohol addiction	Y N

Are you taking anticoagulants (blood thinners)	Y N
Have you ever taken bisphosphonates (for bone loss)	Y N
Are you taking oral contraceptives (birth control)	Y N
Are you currently breastfeeding	Y N
Are you currently pregnant	Y N
Have you or any members of your family had any problem with anesthesia?	Y N

Do you have any other medical conditions not indicated above? Y N

_____

I certify that I understand the questions being asked and that the information provided is truthful and complete.

Signature_____ Date _____

PREMIER
DENTAL PARTNERS

Authorization to Disclose Health Information to Family Members

Patient Name:_____ Date of Birth:____/____/_____

I hereby (PHI) authorize Premier Dental Partners to release my protected health information as described below:

Name	Relationship	Type of Information Allowed to Disclose (Check one or both)		Method of Disclosure (Check one or both)	
		Dental Treatment	Billing/Account Information	By Phone	In Person

Protected Health Information (PHI) may include information/documents regarding dental treatment of the patient, including, but not limited to: diagnosis, procedures, treatment plans, appointments and test results. Billing/account information may include account balances, payments, payment arrangements, insurance claims and explanation of benefits and third-party financing.

I understand that the Health Insurance Portability and Accountability Act of 1996 (HIPAA), govern the terms of this Authorization. I understand that I have the right to revoke this Authorization at any time, provided the revocation is provided to Premier Dental Partners in writing. I further understand that any revocation must include my name, address, telephone number, date of revocation and my signature; and that I should send it to the attention of: Premier Dental Partners HIPAA Compliance Officer.

I further understand that once I authorize this disclosure to the recipient listed above, any re-disclosure by the recipient will no longer be protected by HIPAA.

This Authorization will expire when I am no longer a patient with Premier Dental Partners or have revoked this Authorization.

Other than releases authorized by HIPAA, your PHI will only be released to person(s) listed on this Authorization.

_____ _____

Signature of Patient Authorizing Release of PHI Date

PREMIER
DENTAL PARTNERS

FINANCIAL POLICY

We are pleased that you have selected us as your dental care provider. For your knowledge, our Financial Policy is outlined below.

Promise to Pay. Amounts for dental care services provided to you and your family members may be charged to your Account, unless you specifically instruct us otherwise. You promise to pay us all amounts owed on your Account (your "Balance") under the terms of this Financial Policy when billed. If you have insurance, the amount you owe for services may be estimated based on the amount anticipated to be paid by your insurance company. We will assist you with an insurance claim; however, insurance is a contract between the policyholder and insurance company. The anticipated amount to be paid by your insurance company may be charged to your account until we receive payment from your insurance company. However, in the event your insurance company is slow to pay or disallows a claim, payment of your Account is your full responsibility. We may also charge to your Account fees set forth below for missed appointments, late payments, returned payments or collection costs. We will provide to you a statement (your "Statement") of your Balance, which will be payable when you receive your Statement. We may indicate on your Statement that your Balance is "pending insurance" and thus not yet payable by you. If you have insurance coverage, we may choose not to send you a Statement until we know or receive the amount reimbursable by your insurance company.

Missed Appointment Fee. We may charge to your Account fees for a missed appointment or fees for an appointment cancelled without advanced notice of at least 24 hours.

Late Payment Fee. If we do not receive payment in full of your Balance within 60 days of the date shown on your Statement, you may be assessed a Late Payment Fee based on a percentage of your balance each month. We may not allow further appointments, unless in exceptional circumstances, until we receive full payment of your balance.

Returned Payment Fee. If any check or other payment that you have made on your Account is returned unpaid, you will be charged a Returned Payment Fee, which is currently $30 and may be adjusted.

Collection Costs. If we do not receive payment under the terms of this Financial Policy and we refer your Account to an outside collection agency or an attorney for collection, we may charge to your Account or otherwise collect from you our collection costs, including court costs and reasonable attorneys' fees, to the extent applicable by law.

No Waiver by Us. We may waive our right to charge a fee to your Account without waiving any other right we have under this Financial Policy including our right to charge that same fee at any other time.

Credit Reports. We, or an outside collection agency or attorney, acting on our behalf, may report late payments, missed payments or other defaults on your account to credit reporting agencies. If you believe that we have information about you that is inaccurate or that we have reported or may report to a credit reporting agency information about you that you believe is inaccurate, please notify us of the specific information that you believe is inaccurate by writing to us at the address above.

As used in this Financial Policy, "we", "us", "our", and "Provider" mean the service provider named above. "Services" mean any services provided by us. "You", "your" and "Account holder" mean the person responsible for paying for services. Payment for services is due when services are provided unless as noted otherwise above. By signing below, you are requesting that we establish an open account for you (your "Account") as an accommodation to you for the tracking and payment of amounts due and you agree to the terms of this Financial Policy.

Yes, I agree to the above terms and conditions.

_____/_____/_____

Account Holder's Signature **Print Name** **Date**

****

No, I am not interested in establishing an account and therefore understand that full payment for dental care services, subject to limitations imposed by my insurance company, if any, is due at the time of appointment.

_____/_____/_____

Account Holder's Signature **Print Name** **Date**

SCHEDULING/FINANCIAL POLICY

PREMIER
DENTAL PARTNERS
ORAL SURGERY &
DENTAL IMPLANT CENTER

At Premier Dental Partners Oral Surgery & Dental Implant Center, we continuously strive to provide the best surgical care possible for our patients and part of that service is being able to appoint our patients in a timely fashion. Patients who do not keep their scheduled appointments may delay other patients from being scheduled in a prompt and efficient manner.

- For patients with insurance, please provide the office with current dental and medical insurance information so that we may verify benefits and provide the most accurate treatment estimate. Once insurance has paid, any non-covered patient portions that had been previously estimated to be due from insurance will be due from the patient.

- All anticipated patient balances are due, in full, prior to surgery, on or before the date of service. Our office accepts cash and all major credit/debit cards. We also offer convenient financing through Care Credit (subject to credit approval).

- Prior to scheduling surgical procedures where the patient's portion is estimated to be greater than $1000.00, a $500.00 deposit is required and will be applied to the patients' scheduled procedure.

- Scheduled appointments require at least 24 business hours (3 business days) notice to avoid any cancellation charges. Short cancellation is defined as a cancellation within 24 business hours (3 business days) prior to the appointment. In the event of a short cancellation, deposits that have already been received become non-refundable but may be used towards the cancelled procedure at a later date. Procedures that did not require a deposit to schedule will require a non-refundable $500.00 deposit to schedule a second appointment. Deposits will be forfeited in the event of two, short, cancelled appointments.

- Scheduled surgical appointments where the patient decides not to have surgery and only have a consult (unless medically indicated) will be considered the first short cancellation. A non-refundable deposit will be required to schedule a second surgical visit.

- Patients requiring pain medication (oxycodone, hydrocodone, codeine) or anxiety medications (Xanax, alprazolam) prior to surgery will be required to remit a $500.00, non-refundable deposit (if a deposit for the procedure has not already been collected). The deposit will be forfeited in the event that the procedure is cancelled.

- Fees for full arch dental implant cases (all-on-4) or surgeries scheduled to take place in the operating room are non-refundable in the event of patient cancellation.

We appreciate your understanding of this policy.
I have read, understand, and accept these policies listed above for Premier Dental Partners Oral Surgery & Dental Implant Center.

_____ _____

Patient Signature Date

_____ _____

Witness Date