

**PATIENT REGISTRATION**

ID: \_\_\_\_\_ Chart ID: \_\_\_\_\_

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Patient Is:  Policy Holder Preferred Name: \_\_\_\_\_

Responsible Party

Responsible Party (if someone other than the patient)

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Address: \_\_\_\_\_ Address 2: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ Pager: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Ext: \_\_\_\_\_ Cellular: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Soc Sec: \_\_\_\_\_ Drivers Lic: \_\_\_\_\_

Responsible Party is also a Policy Holder for Patient  Primary Insurance Policy Holder  Secondary Insurance Policy Holder

Patient Information

Address: \_\_\_\_\_ Address 2: \_\_\_\_\_

City: \_\_\_\_\_ State / Zip: \_\_\_\_\_ Pager: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Ext: \_\_\_\_\_ Cellular: \_\_\_\_\_

Sex:  Male  Female  Other Marital Status:  Married  Single  Divorced  Separated  Widowed

Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Soc. Sec: \_\_\_\_\_ Drivers Lic: \_\_\_\_\_

E-mail: \_\_\_\_\_  I would like to receive correspondences via e-mail.

Section 2

Employment Status:  Full Time  Part Time  Retired

Student Status:  Full Time  Part Time

Medicaid ID: \_\_\_\_\_ Pref Dentist \_\_\_\_\_

Employer ID: \_\_\_\_\_ Pref. Pharmacy \_\_\_\_\_

Carrier ID: \_\_\_\_\_ Pref. Hyg.: \_\_\_\_\_

Section 3:

Referred By: \_\_\_\_\_  
Previous Dentist: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_

Emergency Contact #: \_\_\_\_\_

Primary Insurance Information

Name of Insured: \_\_\_\_\_ Relationship to Insured:  Self  Spouse  Child  Other

Insured Soc. Sec: \_\_\_\_\_ Insured Birth Date: \_\_\_\_\_

Employer: \_\_\_\_\_ Ins. Company: \_\_\_\_\_

Address: \_\_\_\_\_ Address: \_\_\_\_\_

Address 2: \_\_\_\_\_ Address 2: \_\_\_\_\_

City,State,Zip: \_\_\_\_\_ City,State,Zip: \_\_\_\_\_

Rem. Benefits: \_\_\_\_\_ .00 Rem. Deduct: \_\_\_\_\_ .00

Secondary Insurance Information

Name of Insured: \_\_\_\_\_ Relationship to Insured:  Self  Spouse  Child  Other

Insured Soc. Sec: \_\_\_\_\_ Insured Birth Date: \_\_\_\_\_

Employer: \_\_\_\_\_ Ins. Company: \_\_\_\_\_

Address: \_\_\_\_\_ Address: \_\_\_\_\_

Address 2: \_\_\_\_\_ Address 2: \_\_\_\_\_

City,State,Zip: \_\_\_\_\_ City,State,Zip: \_\_\_\_\_

Rem. Benefits: \_\_\_\_\_ Rem. Deduct: \_\_\_\_\_

# MEDICAL HISTORY

PATIENT NAME \_\_\_\_\_ Birth Date \_\_\_\_\_

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

- Are you under a physician's care now?  Yes  No If yes, please explain: \_\_\_\_\_
- Have you ever been hospitalized or had a major operation?  Yes  No If yes, please explain: \_\_\_\_\_
- Have you ever had a serious head or neck injury?  Yes  No If yes, please explain: \_\_\_\_\_
- Are you taking any medications, pills, or drugs?  Yes  No If yes, please explain: \_\_\_\_\_
- Do you take, or have you taken, Phen-Fen or Redux?  Yes  No \_\_\_\_\_
- Are you on a special diet?  Yes  No \_\_\_\_\_
- Do you use tobacco?  Yes  No \_\_\_\_\_
- Do you use controlled substances?  Yes  No \_\_\_\_\_

Women: Are you

<input type="checkbox"/> Pregnant/Trying to get pregnant?	<input type="checkbox"/> Nursing?
<input type="checkbox"/> Taking oral contraceptives?	

Are you allergic to any of the following?

<input type="checkbox"/> Aspirin	<input type="checkbox"/> Penicillin	<input type="checkbox"/> Codeine	<input type="checkbox"/> Acrylic	<input type="checkbox"/> Metal	<input type="checkbox"/> Latex	<input type="checkbox"/> Local Anesthetics
<input type="checkbox"/> Other	If yes, please explain: _____					

Do you have, or have you had, any of the following?

<input type="checkbox"/> AIDS/HIV Positive	<input type="checkbox"/> Chest Pains	<input type="checkbox"/> Frequent Headaches	<input type="checkbox"/> Irregular Heartbeat	<input type="checkbox"/> Scarlet Fever
<input type="checkbox"/> Alzheimer's Disease	<input type="checkbox"/> Cold Sores/Fever Blisters	<input type="checkbox"/> Genital Herpes	<input type="checkbox"/> Kidney Problems	<input type="checkbox"/> Shingles
<input type="checkbox"/> Anaphylaxis	<input type="checkbox"/> Congenital Heart Disorder	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Leukemia	<input type="checkbox"/> Sickle Cell Disease
<input type="checkbox"/> Anemia	<input type="checkbox"/> Convulsions	<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Sinus Trouble
<input type="checkbox"/> Angina	<input type="checkbox"/> Cortisone Medicine	<input type="checkbox"/> Heart Attack/Failure	<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Spina Bifida
<input type="checkbox"/> Arthritis/Gout	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Lung Disease	<input type="checkbox"/> Stomach/Intestinal Disease
<input type="checkbox"/> Artificial Heart Valve	<input type="checkbox"/> Drug Addiction	<input type="checkbox"/> Heart Pace Maker	<input type="checkbox"/> Mitral Valve Prolapse	<input type="checkbox"/> Stroke
<input type="checkbox"/> Artificial Joint	<input type="checkbox"/> Easily Winded	<input type="checkbox"/> Heart Trouble/Disease	<input type="checkbox"/> Pain in Jaw Joints	<input type="checkbox"/> Swelling of Limbs
<input type="checkbox"/> Asthma	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Hemophilia	<input type="checkbox"/> Parathyroid Disease	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Blood Disease	<input type="checkbox"/> Epilepsy or Seizures	<input type="checkbox"/> Hepatitis A	<input type="checkbox"/> Psychiatric Care	<input type="checkbox"/> Tonsillitis
<input type="checkbox"/> Blood Transfusion	<input type="checkbox"/> Excessive Bleeding	<input type="checkbox"/> Hepatitis B or C	<input type="checkbox"/> Radiation Treatments	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Breathing Problem	<input type="checkbox"/> Excessive Thirst	<input type="checkbox"/> Herpes	<input type="checkbox"/> Recent Weight Loss	<input type="checkbox"/> Tumors or Growths
<input type="checkbox"/> Bruise Easily	<input type="checkbox"/> Fainting Spells/Dizziness	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Renal Dialysis	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Cancer	<input type="checkbox"/> Frequent Cough	<input type="checkbox"/> Hives or Rash	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Chemotherapy	<input type="checkbox"/> Frequent Diarrhea	<input type="checkbox"/> Hypoglycemia	<input type="checkbox"/> Rheumatism	<input type="checkbox"/> Yellow Jaundice

Have you ever had any serious illness not listed above?  Yes  No If yes, please explain: \_\_\_\_\_

Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN \_\_\_\_\_ DATE \_\_\_\_\_

# Premier Family Dentistry

909 W. Spring Creek Pkwy Ste. 490

Plano, Texas 75023

## Patient HIPAA Consent Form

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payers (e.g. my insurance company)
- The day to day healthcare operations of your practice.

I have also been informed of, and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of the notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this \_\_\_ day of \_\_\_\_\_, 20\_\_

Print Patient Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Signature: \_\_\_\_\_

# Premier Family Dentistry

In order to provide you with the best treatment and keep the cost of the treatment reasonable, we ask that you review our financial policy. We require that you read and sign the following statement and initial next to each paragraph.

## Financial Policy

\_\_\_\_Your portion for services rendered, deductible (if applied) and estimated co-payment are due at the time of service. We are more than happy to assist you with the filing of your insurance, however, keep in mind that the co-pay amount is an **ESTIMATE**. You are responsible for any account balance that is not paid by your insurance. Our policy is that we require your insurance to pay on claims in 60 days. I authorize payment of dental benefits otherwise payable to me directly to Premier Family Dentistry. If your claim becomes outstanding by 60 days, you will be notified on your next statement and the full balance will be due. We will no longer bill secondary insurance claims. A pre-authorization for treatment prior to starting treatment may be sent at your request; however, this is NOT a guarantee of payment by your insurance company.

\_\_\_\_We accept payment in the forms of cash, check, Visa, Mastercard, and Care Credit. **Please be sure of your financial commitment to our office prior to starting any dental treatment.**

If you need any payment arrangements, the following options are available.

- Extended payment options through Care Credit Or Chase (Requires credit check)
- The fee for returned checks is \$35.00

**Arrangements must be made prior to the start of treatment.**

\_\_\_\_We request that in need to cancel an appointment, you give us at least 24 hours notice. If 24 hours is not given, a fee of \$35.00 per hour of the time reserved may be considered and charged to your account.

\_\_\_\_Our billing company manages the mailing of statements for accounts with balances over 60 days old. A finance charge of a periodic rate of 1.25% per month will be imposed on charges not paid in full with 60 days. If your payment is not received by the due date, you may be assessed with a late payment charge of \$5.00 or 5% of the past due amount, whichever is greater. If an account reaches 165 days old or great, an automatic fee of 50% of the balance will be added on the account to cover any fees for collection activity and attorney/court costs that may accrue.

\_\_\_\_In the event of a divorce/separation, the parent/guardian that escorts their child to the dental office will be financially responsible for the payment regardless of an agreement between the parents of the courts.

\_\_\_\_Our office utilizes mercury-free fillings (white fillings). Please be aware that insurances will down grade the price of composite (white) fillings to the silver (mercury or amalgam) filling price. You will be responsible for the difference.

\_\_\_\_Original x-rays/ photos are the property of Premier Family Dentistry. If copies are needed, there is 10 business day turn around on x-ray copies and a \$25.00 fee.

I, \_\_\_\_\_, have read and understood and agree to the above policy. I understand that I am fully responsible for the fees of service rendered regardless of any insurance that I may have.

\_\_\_\_\_

Parent/Responsible Party Signature

\_\_\_\_/\_\_\_\_/\_\_\_\_

Date

**Premier Family Dentistry Treatment Consent Form For:**

**1. EXAMINATIONS AND X-RAYS**

I understand that the initial visit may require radiographs in order to complete the examination, diagnosis, and treatment plan.

Initial \_\_\_\_\_

**2. DRUGS, MEDICATIONS, AND SEDATION**

I understand that antibiotics and analgesics and other medications can cause allergic reactions causing redness and swelling of tissue, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction).

Initial \_\_\_\_\_

**3. CHANGES IN TREATMENT PLAN**

I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the dentist to make any/all changes and additions as necessary.

Initial \_\_\_\_\_

**4. LOCAL ANESTHETIC**

I understand there are risks of local anesthesia that may affect my body such as dizziness, nausea, vomiting, accelerated heart rate, slow heart rate, or various types of allergic reactions. It may also cause injury to nerves that can result in pain; numbness, tingling that may persist for several weeks, months, or rarely, be permanent. I have informed my doctor of my complete medical history including any recent surgeries or changes in my medical history.

Initial \_\_\_\_\_

**5. FILLINGS**

I understand that a more extensive restoration than originally planned, or possibly root canal therapy, may be required due to additional conditions discovered during preparation. I understand that significant changes in response to temperature may occur after tooth restoration. I realize that fillings are rarely "permanent" and usually require periodic replacement with additional fillings and/or crowns

Initial \_\_\_\_\_

**6. REMOVAL OF TEETH**

Alternatives to removal have been explained to me (root canal therapy, crowns, and periodontal surgery, etc.) and I authorize the dentist to remove the following teeth and any others necessary for reasons in paragraph #3. I understand removing teeth does not always remove all the infection, if present, and it may be necessary to have further treatment. I understand the risks involved in having teeth removed, some of which are pain, swelling, and spread of infection, dry socket, loss of feeling in my teeth, lips, tongue and surrounding tissue, (Parasthesia) that can last for an indefinite period of time, or fractured jaw. I understand I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment, cost of which is my responsibility.

Initial \_\_\_\_\_

**7. CROWNS, BRIDGES, CAPS, VENEERS, AND BONDING**

I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that that are being kept on until the permanent crowns are delivered. I realize that the final opportunity to make changes in my new crown, bridge, or cap (including shape, fit, size, and color) will be before cementation.

Initial \_\_\_\_\_

**8. DENTURES- COMPLETE OR PARTIAL**

I realize that full or partial dentures are artificial, constructed of plastic, metal, and/or porcelain. The problems of wearing those appliances have been explained to me including looseness, soreness, and possible breakage. I realize the final opportunity to make changes in my new denture (including shape, fit, size, placement, and color) will be in the "teeth in wax" try-in visit. I understand that most dentures require relining approximately three to twelve months after initial placement. The cost of this procedure is not included in the initial denture fee.

Initial \_\_\_\_\_

**9. ENDODONTIC TREATMENT (ROOT CANAL)**

I realize there is no guarantee that root canal treatment will save my tooth, and that complications can occur from the treatment, and that occasionally metal objects are cemented in the tooth or extend through the root which does not necessarily affect the success of the treatment. I understand that occasionally additional surgical procedures may be necessary following root canal treatment (apicoectomy).

Initial \_\_\_\_\_

**10. PERIODONTAL TREATMENT**

I understand that I have a serious condition causing gum inflammation and/or bone loss, and that it can lead to the loss of my teeth. Alternative treatment plans have been explained to me, including non-surgical cleaning, gum surgery, and/or extractions. I understand that undertaking any procedure may have future adverse effect on my periodontal condition.

Initial \_\_\_\_\_

I understand that dentistry is not an exact science and that therefore reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorized. I acknowledge the receipt of and understand post-operative instructions and have been given an appointment date to return.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

# PREMIER FAMILY DENTISTRY

Sweetea Walia D.M.D

909 W Spring Creek Pkwy

Suite 490

Plano, TX 75023

## VELscope Screening Consent

Our practice continually looks for advances to ensure that we are providing the optimum level of oral health care to our patients. We are concerned about oral cancer and look for it in every patient.

**One American dies every hour from oral cancer.** Late detection of oral cancer is the primary cause that both the incidence and mortality rates of oral cancer continue to increase. It is one of the few types of cancer that has not seen a significant reduction in incidence over the past thirty years, and recent research has shown a strong association with Human Papilloma Virus (HPV), which can be sexually transmitted. For this reason, many oral health care professionals now believe that all individuals over the age of 18 should have at least an annual oral examination. While, age, tobacco, and alcohol use are risk factors for oral cancer, **more than 25% of oral cancer victims have no lifestyle risk factors.**

We have recently incorporated the VELscope into our oral screening standard of care. We find that using the VELscope along with a standard oral cancer examination improves the ability to identify suspicious areas at their earliest stages, **before they are apparent to the naked eye.** The VELscope is similar to proven early detection procedures for other cancers such as mammography, Pap smear, and PSA. A VELscope screening is a simple and painless examination that gives the best chance to find any oral abnormalities at the earliest possible stage, before they become cancerous. Early detection of precancerous tissue can minimize or eliminate the potentially disfiguring effects of oral cancer and possibly save a life.

The VELscope exam will be offered to you annually. This enhanced examination is recognized by the American Dental Association code revision committee as CDT-5 procedure code D0431. More and more insurance companies are covering the cost of the screening however, **this exam is not covered by your insurance.** The fee for this enhanced examination is **\$35.**

I have read the above and understand that this is mandatory for all patients ages 18 and over.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_

# LUMINEERS® BY CERINATE® SMILE EVALUATION

A Simple Quiz to Help You Obtain the Smile You've Always Wanted

## NO PAIN—YOU DON'T EVEN NEED AN ASPIRIN.

### THE MOST SIGNIFICANT COSMETIC ADVANCEMENT...EVER!

Hold a mirror 12"–14" from your face. Smile to show your teeth. Take the time to observe your teeth carefully, then answer the following questions. If you are not happy with the appearance of your teeth, ask your dentist how LUMINEERS can improve your smile.

1 Do you like the appearance of your teeth; your smile?  Yes  No  
If not, explain \_\_\_\_\_



STAINED AND CHIPPED

2 Are your teeth all in alignment (straight)?  Yes  No  
If not, explain \_\_\_\_\_



SPACES

3 Do you have spaces that you don't like?  Yes  No  
If yes, explain \_\_\_\_\_

4 Do you like the color of your teeth?  Yes  No  
If not, explain \_\_\_\_\_



CALCIFICATION STAINS

5 Do you like the shape of your teeth?  Yes  No  
If not, explain \_\_\_\_\_

6 Are your teeth...  
chipped? \_\_\_\_\_ protruding? \_\_\_\_\_ hidden? \_\_\_\_\_



FANGED TEETH

7 Are your teeth wearing on the biting surfaces?  Yes  No  
If yes, explain \_\_\_\_\_



STAINED AND CROOKED TEETH

8 Are there old fillings or dental work you don't like looking at?  Yes  No  
If yes, explain \_\_\_\_\_



PORCELAIN CROWNS

9 What would you like to change the most in the appearance of your teeth?  
\_\_\_\_\_

10 How would you like your teeth to look?  
\_\_\_\_\_  
\_\_\_\_\_



BEAUTIFUL SMILE



LUMINEERS®  
BY CERINATE®  
lumineers.com