Welcome to Premier Dental of Central Ohio

Patient Info

Last Name_____ First Name_____ MI_____

Address:_____ City_____ State_____ Zip_____

Home Phone_____ Work Phone_____ Cell Phone_____

Email_____ Birthday _____/_____/_____

Contact Method: Please check all approved methods for appointment confirmation and billing.

( ) Email ( ) Cell Phone ( ) Home Phone ( ) Work Phone ( ) Texting

Sex: ( ) Male ( ) Female **Marital Status:** ( ) Married ( ) Single ( ) Other ( ) Child

Referral Information

Please place an (x) by **all** the marketing you have received or influenced your visit today

( ) Internet Search ( ) Insurance Company Website ( ) Office Sign ( ) Public Event

( ) Parade ( ) Chamber of Commerce ( ) Mailer ( ) Current Patient Referral

( ) I know the doctor! Dr. _____ ( ) Other. Site exact source _____

Insurance Info

Main Subscriber_____ Date of Birth_____

SSN (or) Member ID_____Your Relationship to subscriber ( ) Self ( ) Spouse ( ) Dependent

Insurance Company Name_____ Phone Number_____

Group Number_____

Dental History

Reason for today's visit_____

Date of last dental care_____ Date of last dental x-rays_____

Former Dentist's Name_____City_____

How often do you floss_____How often do you brush_____

Place an (X) if you have or have had problems with any of the following:

( ) Bad breath	( ) Broken fillings	( ) Sensitivity to hot
( ) Bleeding gums	( ) Grinding teeth	( ) Periodontal treatments
( ) Sensitivity to sweets	( ) Loose teeth	( ) Food collecting between teeth
( ) Clicking or popping jaw	( ) Sensitivity to cold	( ) Sores in your mouth

Medical History

Physicians Name_____Date of last visit_____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen"? These include combinations of lonimin, Fastin (brand names of phentermine), Pndimin (fenfluramine) and Redux (dexfenfluramine)

( ) YES ( ) NO

Have you ever had any serious illnesses or operations? ( ) YES ( ) NO

If yes, please explain_____

Have you ever had a blood transfusion? ( ) YES ( ) NO If yes please provide dates: _____

Women: Are you:

Pregnant? ( ) YES ( ) NO Nursing ? ( ) YES ( ) NO Taking birth control ? ( ) YES ( ) NO

Allergies: Do you have any allergies? ( ) YES ( ) NO. If yes fill in below.

( ) Aspirin	( ) Iodine	( ) Codeine	( ) Barbiturates (Sleeping Pills)
( ) Penicillin	( ) Sulfa	( ) Latex	( ) Local Anesthetic

( ) _____ ( ) _____ ( ) _____

Medical Conditions: Place an (X) by **all** condition you currently have of have had in the past.

( ) Anemia	( ) Congenital Heart	( ) Hepatitis	( ) Scarlet Fever
( ) Arthritis Rheumatism	( ) Cortisone Treatments	( ) Hernia Repair	( ) Shortness of Breath
( ) Artificial Heart Valve	( ) Cough, Persistent	( ) High Blood Pressure	( ) Skin Rash
( ) Artificial Joints, Pins	( ) Cough up Blood	( ) HIV /AIDS	( ) Stroke
( ) Asthma	( ) Diabetes	( ) Jaw Pain	( ) Swelling of the Feet
( ) Back Problems	( ) Epilepsy	( ) Kidney Disease	( ) Swelling of the Ankles
( ) Bleeding Abnormally	( ) Fainting	( ) Liver Disease	( ) Thyroid Problems
( ) Blood Disease	( ) Glaucoma	( ) Tobacco Habitt	( ) Mitral Valve Prolapse
( ) Cancer	( ) Headaches	( ) Pacemaker	( ) Tonsillitis
( ) Chemical Dependency	( ) Heart Murmur	( ) Tuberculosis	( ) Radiation Treatment
( ) Chemotherapy	( ) Heart Problems	( ) Respiratory Disease	( ) Ulcer
( ) Circulatory Problems	( ) Hemophilia	( ) Rheumatic Fever	( ) Venereal Disease

Medications: Are you currently taking any medications ( ) YES ( ) NO If yes please list below.

	Medication Name	Dosage	Purpose
1			
2			
3			
4			
5			

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

You May Refuse to Sign This Acknowledgement

I, _____ have received a copy of this office's Notice of Privacy Practices.
Please Print Name

_____
Signature

_____
Date

Authorization to Release Information

I, _____ authorize the following person(s) to have access to information covered under the Privacy Practice regarding myself.

_____
Please Print Name/Relationship

_____
Please Print Name/Relationship

_____
Please Print Name/Relationship

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practice, but acknowledgement could not be obtained because:

- Individual refused to sign.
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

_____

Payment Options and Notices

We strive to offer payment options that are convenient for you while allowing us to provide a high level of care to all of our patients. At the onset of your treatment, we will provide you with an *estimate* of the total fees expected.

Please understand that treatment plan fees will be *estimates* only. Should the need for additional treatment arise during the course of the original treatment plan, the total fees *could* change. Please be assured that we will notify you of any changes in the total fee and obtain your approval prior to proceeding with treatment.

Please take a moment to review the current financial options available through our office. Should you need assistance with financial options at any time, staff will be available upon your request. Payment plans are at sole discretion of Premier Dental of Central Ohio.

Option 1: Full payment is due on the date of service. For your convenience we accept Cash, Check, Visa and MasterCard. A bookkeeping discount of 10% will be extended to all patients who pay in full prior to the date of service with cash, check or credit card.

Option 2: For treatments that require lab work (crowns, bridges, dentures etc.) 50% payment is due on date of prep and 50% is due on the seating date.

Option 3: We offer third party dental financing through CareCredit and Chase Health Advanced. The application process is very fast and can be done in the office or at your home. These lenders offer interest free plans up to 12 months and other financing plans up to 60 months.

Option 4: Patients with insurance benefits: We will estimate your co-pay as closely to your plan as we can. However, final determination for your service is made by your insurance company. Any positive difference between our estimate and your insurance companies will result in further remittance on your part. As a benefit to patients with dual insurances we will estimate secondary insurance to pay 0%. This will allow you to make treatment decisions using only your primary insurance. Often secondary insurances pay very little and are very difficult to estimate closely.

I_____ have read the above payment options. I understand that I will be held 100% accountable for all services that I (or my child in the case of a minor) receive. After a period of 70 days any balance not paid by my insurance provider will be transferred to my responsibility. Any balances not paid by 90 days will be turned over to collections and 33.3% charge will be added to the remaining balance.

Signature:_____ Date:_____

Patient refunds
As a courtesy, our office will post credits as prepayment for future treatments. Patients wanting a direct refund need to contact our office and execute a refund request. (Initial_____)

Appointments
Three no call, no shows may subject you to dismissal. If you are not confirmed by the day before your appointment by 12 pm, you will lose your appointment. (Initial_____)

ORAL SCREENING CONSENT FORM

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. As with most cancers, age is the primary risk factor for oral cancer. Tobacco and alcohol use are other major predisposing risk factors but **more than 25% of oral cancer victims have no such lifestyle risk factors.** Studies also suggest that human papillomavirus (HPV 16/18) plays a role in more than 20% of oral cancer cases.* Oral cancer risk by patient profile is as follows:

Increased risk: patients ages 18-39; sexually active patients (HPV 16/18)
High risk: patients age 40 and older; tobacco users (age 18-39, any type within 10 years)
Highest risk: patients age 40 and older with lifestyle risk factors (tobacco and/or alcohol use); previous history of oral cancer

We have recently incorporated Indentafi (R) into our oral screening standard of care. We find that using Indentafi along with a standard oral cancer examination improves the ability to identify suspicious areas at their earliest stages. Indentafi is similar to proven early detection procedures for other cancers such as mammography, Pap smear, and PSA. Indentafi is a simple and painless examination that gives the best chance to find any oral abnormalities at the earliest possible stage. Early detection of pre-cancerous tissue can minimize or eliminate the potentially disfiguring effects of oral cancer and possibly save your life. The Indentafi exam will be offered to you annually.

The fee for this enhanced examination is $70.00. Please consult with our office staff to determine what your fee would be with your insurance benefits.

Yes. I would like to have the Indentafi exam today.

Print name:_____

Signature:_____ Date:_____

No. I would prefer not to have the Indentafi exam at this time. Please ask me again at my next visit.

Print name:_____

Signature:_____ Date:_____

*J Natl Cancer Inst. 2003 Dec 3;95(23):1772-83

Ages 18-24 Consent

I, _____ am listed as a dependent on someone else's insurance.
Please Print

Please Mark Appropriate Choice:

o I have been given the opportunity to consent with and/or discuss with main subscriber of insurance my treatment and financial obligations.

o I waive my rights to consent with main subscriber in regards to treatment and financial obligations as I am able to consent for myself.

Signature: _____ Date: _____