PREMIER
Smiles & Implant Dentistry

1461 Ebenezer Road Rock Hill, SC 29732
(803) 324-7461

PATIENT NAME _____ PREFERRED NAME _____ DATE OF BIRTH _____ SEX _____

ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

CELL PHONE NUMBER _____ ALTERNATE NUMBER _____ SSN _____

EMERGENCY CONTACT _____ PHONE NUMBER _____ RELATIONSHIP _____

PREFERRED PHARMACY _____ PHARM. PHONE NUMBER _____ REFERRED BY _____

EMAIL ADDRESS _____

INSURANCE INFORMATION: *PLEASE GIVE INSURANCE CARD TO FRONT DESK STAFF TO MAKE A COPY*

POLICY HOLDER _____ DATE OF BIRTH _____ POLICY HOLDER SSN _____

RELATIONSHIP TO PATIENT _____ INSURANCE NAME _____ INSURANCE PHONE NUMBER _____

ID # _____ GROUP # _____

- Do you take blood thinners? **YES/NO**
- Do you have any artificial joints or have you had a joint replacement? **YES/NO**
  IF YES, WHICH JOINT? _____
- Are you required to premedicate with an antibiotic prior to dental treatment? **YES/NO**
  IF YES, WHY DO YOU PREMEDICATE? _____
- Have you ever taken bisphosphonates? **YES/NO**
  (Fosamax, Actonel, Boniva, Aredia, Zometa)
- Have you had any serious medical trouble associated with any dental experience? **YES/NO**
  IF YES, EXPLAIN: _____
- Have you ever received head/neck radiation for cancer? **YES/NO**

- Have you had a serious illness, operation, or hospitalized within the last year? **YES/NO**
  IF YES, EXPLAIN: _____
- Do you smoke and/or vape any substance? **YES/NO**
  IF YES, HOW OFTEN? _____
- Do you participate in recreational drugs? **YES/NO**
- IF YES, HOW OFTEN? _____

Normal blood pressure reading: _____
When were you last seen by a physician? _____

WOMEN: Are you pregnant, nursing, or taking birth control? **YES/NO**

Do you **currently** take any medications?

_____ _____
_____ _____
_____ _____

Have you ever had any of the following diseases or medical problems? (Circle all that apply)

Abnormal Bleeding
Alcohol/Drug Abuse
Anemia
Anxiety/Depression
Arthritis
Artificial Joints/Bones/Valves
Asthma
Blood Transfusion
Cancer/Chemotherapy
Colitis
Congenital Heart Defect
Diabetes (Type I or Type II)
Mitral Valve Prolapse
Emphysema
Fainting Spells
Frequent Headaches
Glaucoma
Hay Fever
Heart Attack
Heart Murmur
Heart Surgery
Hemophilia
Ulcers
Hepatitis (A, B, C, or D)
Herpes/Fever Blisters
High Blood Pressure
High Cholesterol
HIV/AIDS
Kidney Problems
Liver Problems
Low Blood Pressure
Difficulty Breathing
COPD
Osteoporosis/Paget's Disease
Pacemaker
Parkinson's Disease
Radiation
Seizures/Epilepsy
Sinus Problems
Stroke

Are you allergic to any of the following? (Circle all that apply)
Aspirin, Codeine, Penicillin, Latex, Erythromycin, Tetracycline, Local Anesthetics
Other allergies: _____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

Signature: _____ Date: _____

Physician Name: _____ Phone Number: _____

Dental Questionnaire

How would you rate the condition of your mouth? (Please circle the best answer)
Excellent Good Fair Poor

Previous Dentist Office and Number: _____

Date of Last Dental Visit and X-Ray: _____

Do you have any immediate concerns today? **YES/NO**

IF YES, EXPLAIN: _____

On a scale of 1-10, how important is your dental health? _____

Do you expect to keep your teeth during your lifetime? **YES/NO**

Gums and Bone

Do your gums bleed or are they painful when brushing or flossing? **YES/NO**

Have you been treated for gum disease or been told you've lost bone around your teeth? **YES/NO**

Tooth Structure

What dental work have you had in the past three years? _____

_____

Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth?

If yes, describe below. **YES/NO**

_____

Do you feel you suffer from dry mouth? **YES/NO**

Do you frequently get food caught between your teeth? **YES/NO**

Do you notice yourself grinding your teeth at night or during the day? **YES/NO**

Do you currently wear or have you worn a night guard appliance? **YES/NO**

Smile Characteristics

Rate your smile: (circle one)
Excellent Good Fair Poor

Are you interested in a cosmetic smile consult? **YES/NO**

What would you like to change about your smile? _____

_____

Bite and Jaw Joint

Do you have problems with your jaw joint? (pain, limited, opening, locking, popping) **YES/NO**

Are you concerned about crowding or spacing of your teeth? **YES/NO**

Do you notice your teeth changing (becoming shorter, thinner, more worn, or moving)? **YES/NO**

Authorization for Release of Information- Compound Release

Patient Name: _____

Patient Date of Birth: _____

Premier Smiles and Implant Dentistry is authorized to communicate about the above named patient in the following manner:

Voicemail : Yes ☐ No ☐

Text : Yes ☐ No ☐ Other_____

Email : Yes ☐ No ☐ email address: _____

Regarding: Please check : ☐ All financial, treatment, appointments, and breach notification

Please select if different than all- Financial PHI ☐ Treatment PHI ☐ Appointment Reminders ☐ Breach Notification ☐

Other person(s) authorized to receive communication in regards to the above named-

Please provide name, phone number, and check each person/entity approved to receive communication and the type of information that can be provided.

Name:_____ phone:_____

Regarding: Please check : ☐ All financial, treatment, appointments, and breach notification

Please select if different than all- Financial PHI ☐ Treatment PHI ☐ Appointment Reminders ☐ Breach Notification ☐

Name:_____ Phone:_____

Regarding: Please check : ☐ All financial, treatment, appointments, and breach notification

Please select if different than all- Financial PHI ☐ Treatment PHI ☐ Appointment Reminders ☐ Breach Notification ☐

- I have the right to revoke this authorization at any time by contacting this office
- I may inspect or copy the protected health information to be disclosed as described in this document
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing
-

This authorization will remain in effect until revoked by the patient.

Signature of Patient or Representative:_____ Date:_____

Insurance:
Our fees are determined by our ability to provide you with the highest level of care, skill, and judgement a particular procedure may require. As a courtesy to our patients, we will verify your insurance benefits. Please remember that this is an estimate of coverage based on the most up to date information we have, but is only an estimate. If insurance does not pay within 60 days, we will be happy to re-file or submit any additional information to support your claim. It is important to recognize that the insurance you have is a legal contract between you and your insurance company. Ultimately you are responsible for all charges incurred in our office and for any balance that is not covered by Insurance. We ask you to pay us for services as rendered and be reimbursed directly from your insurance company. If you do not receive payment in a timely fashion, please call your insurance company to determine that status of your claim.

Financial Arrangements:
We are committed to helping our patients get the necessary treatment without financial restrictions. We have several financing options available to help you reach your oral health goals. Payment is due at the time of service. If insurance pays more than expected, we will reimburse you or credit your account for future dental needs. If insurance doesn't pay what we anticipated it will be your responsibility to pay the balance. Please remember insurance is a benefit and it wasn't designed to cover the entire balance.

Appointments:
In order to provide the best quality care, we kindly ask that you give us a minimum of a 48 hours' notice if you need to change an appointment. We understand that emergencies happen. Dr. Raad, Dr. Shirk, Dr. Dastrup, and his team want to be available for your needs and the needs of all of our patients, therefore, if you are more than fifteen minutes late to your appointment, we may have to reschedule you. Thank you for being a valued patient and for your understanding.

HIPAA Acknowledgement:
I understand that I may inspect or copy the protected health information described by this authorization. I understand that at any time, this authorization may be revoked, when the office that received this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my health care will not be affected if I refuse to sign this form. I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by recipient and, if so, may not be subject to federal or state laws protecting its confidentiality.

Authorization and Release:
I authorize Premier Smiles and Implant Dentistry to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child to third parties/ or other health practitioners. I also authorize Premier Smiles and Implant Dentistry to take digital photography to help educate patient on specific dental needs. Photographs will never include your name of face and are solely used for educational purposes.

Photography:
Digital Photography in our office is necessary to help document your dental history and explain future treatment. These photographs may be used for educational purposes including helping educate other patients on specific dental treatments. We also love taking before and after photos of smile transformations to share on social media and our office webpage.
Photographs will never include your name of face without further consent.

Signature: _____ Date: _____

HIPAA and Notice of Private Practices

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications of that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home. Be advised that completing preliminary health and insurance questionnaires does not establish a physical-patient relationship with this practice. An initial evaluation is required to determine whether you are a suitable candidate and whether the practice will accept you as a patient.

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to the uses or disclosures made pursuant to an authorization requested by an individual. Note: Uses and disclosure for TPO may be permitted without prior consent in an emergency. The full version of the notice of Privacy Practices is available at the front desk for you viewing and our website. Please let us know if you would like a copy to take home.

I request that my medical information not be shared with anyone other than another medical provider of a pharmacy. By signing this document, I agree to all of the above.

Patient Signature: _____ Date: _____

Print Name: _____