



PREMIER DENTAL BULVERDE

20540 Hwy 46 #100 Spring Branch TX 78070 • (830) 980-8099 • www.premierdentalbulverde.com

Patient Information

Name: _____
Last First Middle

E-Mail Address: _____ Gender: Male _____ Female _____

Cell Phone: (____) _____ Home Phone: (____) _____ Work Phone: (____) _____

Home Address: _____
Street City State Zip

Date of Birth: ____/____/____ Social Security Number: ____-____-____ Driver's License or ID Number: _____
MM/DD/YYYY

Responsible Party Information (If Patient is a Dependent)

Name: _____
Last First Middle

Relationship to Patient: _____ E-Mail Address: _____

Cell Phone: (____) _____ Home Phone: (____) _____ Work Phone: (____) _____

Home Address: _____
Street City State Zip

Date of Birth: ____/____/____ Social Security Number: ____-____-____ Driver's License or ID Number: _____
MM/DD/YYYY

Dental Insurance Information (Please Provide a Copy of Your Card)

Name of Primary Policy Holder: _____
Last First Middle

Primary Policy Holder's Date of Birth: ____/____/____ Primary Policy Holder's SS/ Member ID Number: ____-____-____
MM/DD/YYYY

Primary Policy Holder's Employer: _____

Insurance Company Name: _____ Group Number: _____ Insurance Company Phone: (____) _____

Insurance Company Address: _____
Street City State Zip

Emergency Contact Information

Local Friend or Relative not Living with You: _____ Emergency Contact Phone: (____) _____

Emergency Contact Address: _____
Street City State Zip

Getting to Know You

Why did you select our office? _____ Whom May we thank for referring you? _____

Is another member of your family already a patient with our practice? Yes No Family Member? _____

When was your last dental visit? _____

When was the last time you had complete dental x-rays taken? _____ Have you ever had any teeth removed? _____

How long have these teeth been missing? _____

How Have these teeth been replaced? Bridge Partial Denture Implants They have not been replaced

FOR ALL PATIENTS

I authorize the doctor to perform any and all forms of treatment, medication and therapy that may be indicated in connection with the dental care of the patient above, and further authorize and consent that the doctor chooses and employs such assistance as he deems fit. I also understand that prior to treatment, full explanation of the procedure(s) involved will be given by the doctor and/or his staff. I agree to pay for all services rendered by this office.

SIGNATURE OF RESPONSIBLE PARTY

RELATIONSHIP TO PATIENT

DATE

HEALTH HISTORY

Name: _____ Date: _____
Birth Date _____ Height _____ Weight _____ Age _____ Gender: M F

Please list all medical problems you are currently being treated for: _____

Please list all of your previous surgeries: _____

Please list any drug, food or latex allergies: _____

Please list your current medications: including aspirin or any other over the counter medications: _____

DO YOU HAVE, OR HAVE YOU EVER HAD....

- | | | |
|--|---|---|
| <input type="checkbox"/> Yes <input type="checkbox"/> No Chest pain | <input type="checkbox"/> Yes <input type="checkbox"/> No Tuberculosis | <input type="checkbox"/> Yes <input type="checkbox"/> No Bleeding/blood clot problems |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Heart attack | <input type="checkbox"/> Yes <input type="checkbox"/> No Tobacco use | <input type="checkbox"/> Yes <input type="checkbox"/> No Anesthetic problems |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Irregular heart beat | <input type="checkbox"/> Yes <input type="checkbox"/> No Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No Epilepsy/seizures |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Pacemaker/defibrillator | <input type="checkbox"/> Yes <input type="checkbox"/> No Liver disease | <input type="checkbox"/> Yes <input type="checkbox"/> No Glaucoma/eye problems |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Heart murmur | <input type="checkbox"/> Yes <input type="checkbox"/> No Kidney disease | <input type="checkbox"/> Yes <input type="checkbox"/> No Ulcers/gastric reflux |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Angioplasty/bypass | <input type="checkbox"/> Yes <input type="checkbox"/> No Thyroid disease | <input type="checkbox"/> Yes <input type="checkbox"/> No History of alcohol or drug abuse |
| <input type="checkbox"/> Yes <input type="checkbox"/> No High blood pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No Rheumatic fever | <input type="checkbox"/> Yes <input type="checkbox"/> No Currently pregnant/nursing |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Heart valve replacement | <input type="checkbox"/> Yes <input type="checkbox"/> No Immune system problems | <input type="checkbox"/> Yes <input type="checkbox"/> No Hip/knee/joint replacement |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No Hepatitis/jaundice | <input type="checkbox"/> Yes <input type="checkbox"/> No Blood thinners |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Shortness of breath | <input type="checkbox"/> Yes <input type="checkbox"/> No Cancer | <input type="checkbox"/> Yes <input type="checkbox"/> No Bone density medication |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Emphysema/COPD | <input type="checkbox"/> Yes <input type="checkbox"/> No Chemotherapy | <input type="checkbox"/> Yes <input type="checkbox"/> No Require antibiotics prior to surgery |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Sleep apnea | <input type="checkbox"/> Yes <input type="checkbox"/> No Radiation therapy | |

DENTAL HISTORY (PLEASE CHECK ALL THAT APPLY):

- Routine care only Orthodontics Jaw/tooth trauma TMJ problems Jaw surgery
 Gum disease Cancer Mouth sores Dental implants Dentures

Please list anything else about your medical or dental history we should know: _____

Signature-Patient/Guardian

Dr's initials

UPDATED: _____ DATE: _____

Our goal is to make your experience in our office exactly how you want it to be. Please take a few moments and complete this profile so we can be of service to you as comfortable as possible.

1. Please rate the following statements regarding what is most important to you in dental care so we can best serve you: (#1 being the most important)

___ Long-Term Preventative Care...I have healthy teeth and want to keep them that way.

___ Creating a Comprehensive Overall Dental Care Plan...I want to Invest in my Teeth and Appearance

___ Dental Care is budget driven. I will have to plan financially for any treatment beyond my immediate needs.

___ Other Goals: _____

2. Please circle how important is it for you to keep your teeth for a lifetime? (10 being very important)

1 2 3 4 5 6 7 8 9 10

3. Are you concerned about: (please circle yes or no)

Replacing missing teeth Yes No Straightness of your teeth or bite Yes No

Eliminating any cavities Yes No Snoring at night Yes No

Gum disease Yes No Color of your teeth Yes No

Bad breath Yes No Appearance of your smile Yes No

4. Are you or anyone in your family interested in a **complimentary** orthodontic (Braces or Invisalign) consultation with our Orthodontist? Yes No

We know dental care can be very stressful for most people. Please share your concerns and past experiences to help guide us in serving you and your family more effectively.

5. Please circle the level of fear you have regarding dental treatment for yourself. (10 being the most fearful, 1 being the least amount of fear)

1 2 3 4 5 6 7 8 9 10

6. When we review your treatment plan with you, would you like to know (please check one):

___ I am a big picture type person; I prefer to review the plan looking at all the things that need to be done.

___ I am a detail-oriented person, I prefer to approach each treatment step along the way

7. Please briefly describe any bad dental experiences you have had: _____

THANK YOU

DENTAL INSURANCE POLICY

Premier Bulverde proudly accepts most dental insurance plans. We file all dental insurance claims as a patient courtesy. In the event of a treatment plan, we create a reasonable estimate of patient co-payments and insurance contributions. This estimate is based on contracted insurance rates, the general breakdown of benefits obtained through the insurance verification process and our knowledge of common insurance exclusions. **This estimate is not a guarantee of insurance payment. All benefit determinations are at the discretion of the insurance company and are not determined until after a claim is submitted.** We provide treatment estimates as a courtesy in order to minimize the total out-of-pocket cost due by the patient. **All estimated patient co-payments are due on or before time of service.**

Patient is responsible for any remaining account balance resulting from insurance nonpayment or underpayment. A statement will be mailed to you regarding this balance. Payment is due immediately upon receipt.

-----PATIENT ACKNOWLEDGMENT AND AUTHORIZATION-----

I understand and agree to the Dental Insurance Policy stated above. I authorize all my insurance companies to make payment directly to Premier Bulverde This assignment will remain in effect unless revoked by me in writing. I understand I am financially responsible for all charges whether or not paid by said insurance company. Further, I authorize the release of any patient information necessary to process these claims.

Signature: _____ Date: _____

APPOINTMENT DEPOSIT REQUIREMENT

Premier Bulverde requires a minimum \$50.00 deposit for all appointments requiring 90 minutes or more of estimated chair-time and for all appointments with a total treatment cost of \$300.00 or more. The deposit operates as a credit on the patient account towards the total patient portion due on or before time of service. Premier Bulverde requires this deposit because our providers and dental assistants reserve the appointment time specifically for you at the exclusion of other patients. **The deposit requirement is subject to our Cancellation Policy.**

The deposit requirement is reserved only for those patients choosing not to pre-pay for their services in full when scheduling the appointment.

I understand and agree.

Signature: _____ Date: _____

CANCELLATION POLICY

Premier Bulverde makes an effort to see patients on time in order to give patients they care they deserve. Therefore, we ask that you **please give 48 hours notice if you are unable to keep your scheduled appointment. We reserve the right to charge a cancellation fee of \$50.00 in the event of two (2) or more missed appointments lacking proper notice.** We will make exceptions in the event of reasonable emergencies.

I understand and agree.

Signature: _____ Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICES

I, _____, have had the opportunity to review Premier Bulverde Notice of Privacy Practices (the entire legal notice is displayed at the front desk).

Signature: _____ Date: _____