Premier Denture Center

"A Perfect For You Smile."

PATIENT INFORMATION AND HEALTH HISTORY

DATE _____

Patient Name:Mr./Mrs./Miss _____

Single Married Divorce Separated Widowed

Home Address _____ Apt. No. _____

City _____ State _____ Zip Code _____

Telephone No. (Home) _____ (Cell) _____ (Work) _____

Email _____

Sex ☐ Male ☐ Female Birthdate _____ Age _____ Weight _____

Employer Name _____ Occupation _____

Employer Address _____ State _____ Zip Code _____

Dental Insurance ☐ Yes ☐ No Company Name _____

Company Address _____ State _____ Zip Code _____

Company Telephone No. _____ Social Security No. _____ Policy No. _____

Medical Doctor's Name _____ Doctor's Telephone No. _____

Doctor's Address _____ State _____ Zip Code _____

Current Medical Treatments _____

Current Medications _____

Dentist's Name _____ Dentist's Telephone No. _____

Date of last Physical Examination _____ Date of last Dental Examination _____

IN CASE OF EMERGENCY, CONTACT:

Name _____ Relationship _____

Telephone No. (Home) _____ (Cell) _____ (Work) _____

Do you currently wear Dentures? ☐ Yes ☐ No For How Long? _____

How old are your present Dentures? _____ How many sets of Dentures have you had? _____

Have your Dentures been Relined? ☐ Yes ☐ No How often? _____ Date of last Reline _____

Have your Dentures been Repaired? ☐ Yes ☐ No If Yes, why? _____

Do you currently wear Partials? ☐ Yes ☐ No ☐ Acrylic Base ☐ Metal Frame

What problems have you had OR do you have with your Dentures or Partials? _____

_____

over→

DENTAL HISTORY

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING – INDICATE WITH A √

- ☐ Bad breath
- ☐ Bleeding Gums
- ☐ Blisters on lips or mouth
- ☐ Burning sensation on tongue
- ☐ Chew on one side of mouth
- ☐ Clenching or Grinding teeth
- ☐ Clicking or Popping jaw
- ☐ Cigarette, pipe, or cigar smoking
- ☐ Dry mouth
- ☐ Finger nail biting
- ☐ Food collection between teeth
- ☐ Gums swollen or tender
- ☐ Jaw pain or tiredness
- ☐ Lip or cheek biting
- ☐ Loose teeth or broken fillings
- ☐ Mouth breathing
- ☐ Mouth pain, brushing
- ☐ Orthodontic treatment
- ☐ Pain around ear
- ☐ Periodontal treatment
- ☐ Sensitivity to cold or hot
- ☐ Sensitivity to pressure / biting
- ☐ Sores or growths in mouth
- ☐ Unpleasant taste

MEDICAL HISTORY

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING – INDICATE WITH A √

- ☐ AIDS/HIV
- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artificial Heart Valves
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Back Problems
- ☐ Bleeding abnormally
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Congenital Heart Lesions
- ☐ Cortisone Treatments
- ☐ Cough, Persistent or bloody
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy/Seizures/Convulsion
- ☐ Fainting or dizziness
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Hepatitis Type_____
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Jaw Pain
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Nervous or Emotional Disorders
- ☐ Pacemaker
- ☐ Psychiatric Care
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Shortness of Breath
- ☐ Sinus Trouble
- ☐ Skin Rash
- ☐ Special Diet
- ☐ Stroke
- ☐ Swollen Feet or Ankles
- ☐ Swollen Neck Glands
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Tumor/Growth on Head / Neck
- ☐ Ulcer
- ☐ Venereal Disease
- ☐ Weight Loss / Gain

Allergies

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING – INDICATE WITH A √

- ☐ Aspirin
- ☐ Barbiturates (Sleeping Pills)
- ☐ Codeine
- ☐ Iodine
- ☐ Latex
- ☐ Metal
- ☐ Novocaine
- ☐ Penicillin
- ☐ Sulfa
- ☐ Sedatives

I verify that I have read and understand all the questions asked in the health questionnaire. I also verify to the best of my knowledge, the above questions have been accurately answered. I have been informed that my physician or dentist may be contacted and consulted to help ensure safe dental treatment.

Patient Signature:_____ **Date:**_____

PATIENT INFORMATION (Continued)

- To the best of my knowledge, I have no medical / health conditions that would prevent me from wearing dentures or partials.
- I FULLY UNDERSTAND if I am having dentures made there is a minimum of three to four appointments to the process.
- I UNDERSTAND that all DENTURES / PARTIALS made by Premier Denture Center may need adjustments after the insert date. There is no cost for the first 10 adjustments within 90 days from the original date of insert. Adjustments needed over 10 visits within the 90 days or after the 90 days from the original insert date will be charged as a separate fee item.
- I FULLY UNDERSTAND Rebase/Relines done by Premier Denture Center may need adjustments after the date of insert. There is no cost for the first 4 adjustments within 60 days from the date of insert. Adjustments needed over 4 visits within the 60 days or after the 60 days from the date of insert will be charged as a separate fee item.
- I FULLY UNDERSTAND that there is NO GUARANTEE on repairs.
- I FULLY UNDERSTAND that there is NO GUARANTEE on repairs rebase/relines, or adjustments to dentures and or partials that have been made elsewhere, by another dental provider.
- I FULLY UNDERSTAND that there will be NO REFUNDS for Exams, Professional Services Rendered and special ordered items (example: teeth; attachments, etc.).
- I FULLY UNDERSTAND that photographs may be taken for professional use.

PAYMENT POLICY: Our policy requires ½ of the total amount due, to be paid at the 1st appointment. The balance is due at the time the denture is given to the patient or the final appointment, unless, other payment arrangements are made. As a general policy, we do not make payment arrangements. For all other services, payment is due at the time of service. We accept credit cards, debit cards, checks, cash and most insurances.

INSURANCE POLICY: Our POLICY requires that the patient's portion of the amount due, is to be paid at the time impressions are taken. The balance due is the responsibility of the patient if the insurance company denies the claim.

I UNDERSTAND that a PRE-DETERMINATION may be required for all insurance claims and DSHS claims. This may include a long waiting period for DSHS patients, and a brief wait while private insurance makes their decisions.

- I hereby authorize my insurance benefits to be paid directly to PREMIER DENTURE CENTER.
- I understand that I am responsible for any and all services/charges which are not covered by insurance.

I HAVE READ AND UNDERSTAND ALL OF THE ABOVE POLICIES. I declare that I have answered all questions honestly, to the best of my ability. I AGREE to the terms above and authorize Premier Denture Center, to perform the services necessary to create, repair, rebase/reline or adjust my dentures or any other service I might request or need in regards to my dental prosthetics.

X_____ _____

Signature of Patient / Subscriber / Guardian Date

BELOW IS FOR OFFICE USE ONLY:

Treatment and Care Instructions:

- I have been instructed about the follow-up treatment and the care of my dentures / partials.
- I have received and I am accepting my dentures / partials made by Premier Denture Center.

X_____ _____

Signature of Patient / Subscriber / Guardian Date

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PATIENT TREATMENT CONSENT

Dentures, Complete or Partial

I, The undersigned, hereby state that:
I consent to the performance of dentures, complete or partial. I understand that dentures are not a replacement for natural teeth, which are held in by roots. Muscles and suction will hold in the dentures.

I understand that a lower denture is harder to keep in place than an upper denture. This is because, unlike upper dentures that cover the palate and create a 360° seal, a lower denture has no suction.

I understand that the tongue has a tendency to unseat the lower denture when swallowing and talking. I understand that front teeth are aesthetic and just for "show". I will need to learn to bite and chew on the back teeth, where the ridge can support the bite.

I realize that full or partial dentures are artificial, constructed of acrylic, metal, plastic and/or porcelain. The problems of wearing these appliances have been explained to me, including looseness, soreness and possible breakage. I understand that I am not just purchasing dentures, complete or partial, that my treatment involves not only the appliances themselves and professional expertise, but also my active participation and patience in my own treatment.

I have seen and understand the PATIENT TREATMENT CONSENT form.

Printed Name: _____

Patient Signature:_____ Date: _____

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PATIENT AUTHORIZATION

HIPPA is the Health Insurance Portability an Accountability Act. It was passed in 1996 and went into effect on April 14th, 2003. What this law requires is that we tell you who we share your dental information with, which would be anyone involved with treatment and anyone involved with payment. This includes your insurance carrier, any laboratories, specialists, and collection agencies.

I have seen and understand the statement of Privacy Practice.

x_____
Signature

May we leave messages on an answering machine regarding appointments?

Yes ☐ No ☐

May we mail out recall postcards?

Yes ☐ No ☐

Would you like us to be able to discuss your dental health or treatment plan with another family member or friend? Yes ☐ No ☐

Name:_____

Printed Name: _____

Patient Signature:_____ Date: _____

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FINANCIAL POLICY

Fees will be provided before services are rendered, and payment is required at the time services are performed.

For new dentures or partial dentures your required deposit is half down upon acceptance of treatment and impressions taken. The remaining balance is to be paid in full by the delivery appointment. For all other services (repairs, relines, rebases) payment is due upon acceptance of treatment. Each fee is individual for the individual patient.

To avoid misunderstanding regarding dental insurance, our patients should know that all professional dental services rendered are charged directly to the patient and that patients are responsible for payment of fees. We will prepare necessary forms or reports to help you obtain your benefits from insurance companies, upon receipt of full payment of bill. We do not render our services on the basis that insurance companies will pay all our fees. It is the patients' responsibility to check with their insurance company to insure their coverage for payment.

Payments may be made by cash, checks, debit or credit cards.
(We accept Visa, Master Card, American Express, and Discover).

Financing available through Care Credit and Citi Health Card.

There will be a $50.00 charge for all returned checks.

I agree to and understand the above statements.

Printed Name: _____

Patient Signature: _____ Date: _____