Med. Alert____ Pre-Med____ Allergies____ DATE:_____

Prestige
DENTAL CENTERS

PATIENT INFORMATION

Patient Name: _____ Preferred Name: _____ Birthdate: _____

Telephone: _____ Work: _____ Cell Phone: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Soc. Sec. Number: _____ E-Mail Address: _____

Emergency Contact: _____ Relationship: _____ Emergency Phone: _____

If patient is a minor, who is legally responsible? Please list name and phone number:

_____

Whom may we thank for referring you? _____

INSURANCE INFORMATION

Name of Primary Insurance: _____ Group #:_____ Employer:_____

Insurance Address: _____ Phone #:_____

Employee/Subscriber: _____ SSN#: _____ Birthdate: _____

Is the patient covered by a secondary dental plan? _____

Name of Secondary Insurance: _____ Group #: _____ Employer: _____

Insurance Address: _____ Phone #:_____

Employee/Subscriber: _____ SSN#: _____ Birthdate: _____

APPOINTMENT POLICY

We understand that your time is valuable, as is ours. Dr. Rogers and Dr. Bull, along with our team, reserve time in their schedules just for you. Therefore, we require a 48-hour notice of cancellation for all appointments. We reserve the right to apply a $50 fee for each appointment time missed. It is the patient's responsibility to be aware of his or her schedule appointments. If the correct information is provided, a reminder text or email will be sent to you as a courtesy.

To my knowledge, all of the information provided above is correct. I have read and understand the Appointment Policy provided to me.

Signature of Patient or Parent / Guardian: _____ Date: _____

Your answers are for our records only and will be kept confidential in accordance with applicable laws.

What concerns do you have today? _____
Date of your last dental visit (if not at our office): _____

Yes	No	
□	□	Are you happy with the appearance of your teeth?
□	□	Is fear, lack of time, or cost holding you back from a perfect smile?
□	□	Are you happy with the shade of your teeth?
□	□	Are you interested in correcting your smile/bite using clear aligners?
□	□	Are your gums or teeth sensitive?
□	□	Do your gums bleed when you brush?
□	□	Does food catch between your teeth?
□	□	Have you ever had periodontal treatment?
□	□	Have you ever had orthodontic treatment?

Yes	No	
□	□	Do you have headaches, earaches, or neck pain?
□	□	Does your jaw click or pop?
□	□	Do you grind or clench your teeth?
□	□	Are you interested in preventative dentistry?
□	□	Are you anxious or fearful of treatment?
□	□	Do you or any member(s) of your family have A history of oral cancer?

MEDICAL INFORMATION

Physician Name_____ Date of last visit_____

Yes	No	Don't Know	
□	□	□	Are you currently undergoing medical treatment? If yes, please describe:_____
□	□	□	Are you taking any medications? Please list here:_____
□	□	□	Have you had any major surgeries? If yes, please list and give approximate year: _____
□	□	□	Are you taking, or have you taken any diet drugs? (Pondimin, Redux, Phen-fen)
□	□	□	Do you use tobacco (smoking, chew, snuff)? Frequency and amount:_____
□	□	□	Have you taken or are you taking bisphosphonates?
□	□	□	Have you ever been told you need to take antibiotics prior to dental treatment? If yes, for what?_____
	Females:		
□	□	□	Are you pregnant? Due Date: _____ Nursing? _____
□	□	□	Are you taking birth control?

Allergies:

Yes	No	Don't Know	Yes	No	Don't Know	
□	□	□ Local Anesthetics	□	□	□	Latex
□	□	□ Aspirin	□	□	□	Iodine
□	□	□ Penicillin or other antibiotics	□	□	□	Codeine or other narcotics_____
□	□	□ Barbiturates, sedatives or sleeping pills	□	□	□	Metals (Nickle, Copper,etc.)_____
□	□	□ Sulfa drugs	□	□	□	Other, please specify:_____

To yes responses, specify type and reaction _____

_____

Do you have a history of, or do you currently have any of the following?

Yes	No		Yes	No		Yes	No	
□	□	Abnormal bleeding	□	□	Heart attack/Date:_____	□	□	Migraines or frequent headaches
□	□	AIDS or HIV	□	□	Heart disease/failure	□	□	Neurological disorders
□	□	Anemia	□	□	Artificial heart valves	□	□	Organ transplant
□	□	Arthritis/gout	□	□	Cardiac stents	□	□	Osteoporosis
□	□	Rheumatoid Arthritis	□	□	Congenital heart disease or birth defect	□	□	Persistent swollen neck glands
						□	□	Respiratory disorder
□	□	Asthma	□	□	Pacemaker	□	□	Sensory disorder
□	□	Blood transfusion	□	□	Hemophilia or other blood clotting disorder	□	□	Sexually transmitted infection
						□	□	Shortness of breath
□	□	Cancer / Chemo / Radiation	□	□	Hepatitis/jaundice/liver disease	□	□	Sinus trouble
□	□	Chemical Dependency	□	□	Herpes/cold sores/fever blisters	□	□	Sleep disorder/apnea
□	□	Chest Pain Upon Exertion	□	□	High blood pressure	□	□	Slow healing wounds
□	□	Chronic Pain	□	□	High cholesterol	□	□	Sores or ulcers in mouth
□	□	Cough, persistent or bloody	□	□	HPV infection	□	□	Steroid/cortisone therapy
□	□	Depression and/or anxiety	□	□	Hypoglycemia	□	□	Stroke/date:_____
□	□	Developmental disorder	□	□	Immunosuppression	□	□	Swelling of ankles and feet
□	□	Diabetes**(CIRCLE:Type I /Type II)**	□	□	Infective endocarditis	□	□	Systemic lupus erythematosus
□	□	Dry mouth	□	□	Joint replacement	□	□	Thyroid condition
□	□	Eating disorder	□	□	Kidney disease	□	□	Tonsilitis/tonsillectomy
□	□	Fainting spells or seizers	□	□	Low blood pressure	□	□	Tuberculosis
□	□	GE / acid reflux	□	□	Lung disease/emphysema/COPD	□	□	Tumors/growths on head or neck
□	□	GI disorders / Ulcers	□	□	Mental health disorder	□	□	Unexplained weight loss
□	□	Glaucoma						

Please provide details for any above checked items:

_____

_____

I certify that I have read and understand the above. I acknowledge that my questions, if any, have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Preferred Pharmacy: _____

Signature of Patient or Parent / Guardian: _____ Date: _____

Prestige
DENTAL CENTERS

PATIENT CONSENT FORMS

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you take action relying on this consent.

Patient Name: _____

Signature: _____

Relationship to Patient: _____

Date: _____

Prestige
DENTAL CENTERS

APPOINTMENT AND FINANCIAL POLICY

Appointment Policy

We understand that your time is valuable, as is ours. Dr. Rogers and Dr. Bull, along with our team, reserve time in their schedules just for you. Therefore, we require a 48-hour notice of cancellation for all appointments. We reserve the right to apply a fee of $50.00 for each appointment time missed. It is the patients' responsibility to keep his or her appointment(s). A reminder call, text, and email (if the information to do so is present) are given to you as a courtesy.

Financial Policy

Payment – Payment is due at the time services are rendered, unless financial arrangements have been made. We accept cash, check, Visa, and MasterCard.

Insurance Filing – As a courtesy, we will file claims for our patients. We do not guarantee insurance benefits. It is the patient's responsibility to know and understand their insurance benefits, and to provide us with the correct insurance information including a dental insurance card if provided by your carrier. It is your responsibility to notify us prior to your appointment of any changes with your insurance. It is the patient's responsibility to follow up with any unpaid claims. The guarantor/patient is responsible for any unpaid balances.

Statements – You will receive statements from our office. If you are not able to clear your balance in 30 days (from the date of services), an arrangement will need to be made with our business manager to pay. Those patients whose insurance carriers take an inordinate amount of time to settle a claim will be required to make monthly payments until the insurance pays. Once insurance pays if there is a credit on your account, we can either apply it to future treatment or simply reimburse you. Accounts not paid or maintained on a current basis after 90 days will be subjected to collection action.

Collection Accounts – Any account past due will be subjected to a finance charge of 18% annum added to the bill. If your account becomes delinquent, it may be forwarded to an outside collection agency without notice. If this happens, you will be responsible for all cost of collection, including but not limited to interest, rebilling fees, court costs, attorney fees, and collection agency costs.

Assignment of Benefits

I hereby authorize payment directly to Prestige Dental Centers. I agree to be personally and fully responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist has a contractual agreement with my plan prohibiting all or a portion of such charges. This instruction to you is an assignment of my rights under my dental/medical coverage and therefore acts as a "signature on file" for all billing and insurance purposes. I state and agree that a photo static copy of this document shall be considered as effective and valid as the original for all parts of this contract.

Signature: _____ Date: _____

Prestige
DENTAL CENTERS

General Consent

Thank you for choosing our office for your dental care. We continually work with you to help you achieve excellent oral health. While recognizing the benefits of a pleasing smile and teeth that function well, you should be aware that dental treatment, like treatment of any other part of the body, has some inherent risks. These are seldom great enough to offset the benefits of treatment, but should be considered when making treatment decisions.

Benefits of dental treatment can include: relief of pain, the ability to chew properly, and the confidence and social interaction that a pleasing smile can bring. Nonetheless, there are some common risks associated with virtually any dental procedure including:

1. **Drug or chemical reaction:** Dental materials and medications may trigger allergic or sensitivity reactions.
2. **Long-term numbness (paresthesia):** local anesthetic, or its administration, while almost always adequate to allow comfortable care, can result in transient, or in rare instances, permanent numbness.
3. **Muscle or joint tenderness:** Holdings one's mouth open can result in tenderness or in a predisposed patient precipitate a TMJ disorder.
4. **Sensitivity in teeth or gums, infection, or bleeding.**
5. **Swallowing or inhaling small objects.**

While we follow procedural guidelines which most often lead to clinical success, just like in any other pursuit in health care, not everything turns out the way it is planned. We will do our best to assure that it does. Please feel free to ask questions in regard to all dental procedures that are recommended to you.

Text and Email Appointment Confirmations

By enrolling in text and email appointment confirmations, you are authorizing Prestige Dental Centers to send text and email message appointment reminders to you on your provided cell phone number and email address. You may reply to these messages with the number given to confirm your appointment.

You also agree that all individuals associated with your account may receive alerts referencing their appointments. Text message charges from your cell phone carrier may apply.

The text message system is provided by Prestige Dental Centers to our patients on an as-is basis. Data obtained from you in connection with the text message system may include, but not limited to, your name, address, cell phone number, email address, dental office and location, future appointment dates and times. Prestige Dental Centers is not liable for any delays that may be experienced during the transmission of any messages, as delivery is based on the speed and effectiveness of your wireless provider.

Opt-In and Opt-Out Policy You may opt-out of our text message system by sending "STOP" to the text message you have received. You may also contact our office to let us know you would like to opt out. You will no longer receive confirmation if you opt-out of this service.
I have read and understand the statement on this page.

Signature: _____ Date: _____

Parent / Guardian Signature (if minor patient):_____ Date: _____