

# PREMIER DENTAL NEW BRAUNFELS

1583 Common Street Ste. 205 New Braunfels TX 78130 • (830) 625-2111 • www.premierdentalnb.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....

- Yes No Chest pain Tuberculosis Bleeding/blood clot problems
Yes No Heart attack Tobacco use Anesthetic problems
Yes No Irregular heart beat Diabetes Epilepsy/seizures
Yes No Pacemaker/defibrillator Liver disease Glaucoma/eye problems
Yes No Heart murmur Kidney disease Ulcers/gastric reflux
Yes No Angioplasty/bypass Thyroid disease History of alcohol or drug abuse
Yes No High blood pressure Rheumatic fever Currently pregnant/nursing
Yes No Heart valve replacement Immune system problems Hip/knee/joint replacement
Yes No Asthma Hepatitis/jaundice Blood thinners
Yes No Shortness of breath Cancer Bone density medication
Yes No Emphysema/COPD Chemotherapy Require antibiotics prior to surgery
Yes No Sleep apnea 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 Dental New Braunfels 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 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 Dental New Braunfels 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 Dental New Braunfels 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 Dental New Braunfels 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 Dental New Braunfels makes an effort to see patients on time in order to give patients the 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 Dental New Braunfels Notice of Privacy Practices (the entire legal notice is displayed at the front desk).

Signature: \_\_\_\_\_ Date: \_\_\_\_\_