PATIENT INFORMATION

Seminole Premier DENTAL

PATIENT'S NAME _____ Today's Date _____
Home Address _____ SSN _____
City, State, Zip _____ Date of Birth _____
Email _____ Home Phone _____
Patient's Employer _____ Work Phone _____
Driver's License # _____ Mobile Phone _____

INSURANCE COMPANY _____ Phone _____
Subscriber Name _____ Date of Birth _____
Employer _____ Work Phone _____
SSN or ID# _____ Group # _____

IF PATIENT IS A MINOR
Parent/Guardian Name _____ Home Phone _____
SSN _____ Date of Birth _____

Are you taking any medications? ☐ **Yes** ☐ **No** **Please List:** _____

MEDICAL HISTORY

Have you ever had? (Check box to the left)

Yes	No		Yes	No	
☐	☐	Heart Murmur/MVP	☐	☐	Migraine/Headaches
☐	☐	Heart Disease	☐	☐	Currently Pregnant/Breastfeeding
☐	☐	Rheumatic Fever	☐	☐	Herpes
☐	☐	High Blood Pressure	☐	☐	Immunocomprised
☐	☐	Liver Disease	☐	☐	Chest Pain
☐	☐	HIV Positive	☐	☐	Radiation/Chemo Therapy
☐	☐	Diabetes	☐	☐	TMJ Problems
☐	☐	Lung Disease/Asthma	☐	☐	Pacemaker
☐	☐	Excessive Bleeding	☐	☐	Prosthetic Implant
☐	☐	Thyroid Problems	☐	☐	Joint Replacement
☐	☐	Hepatitis	☐	☐	Arthritis
☐	☐	Tuberculosis	☐	☐	Heart Attack
☐	☐	Epilepsy	☐	☐	Stroke

Do you have any allergies?

Yes	No		Yes	No	
☐	☐	Aspirin	☐	☐	Codeine
☐	☐	Penicillin	☐	☐	Latex
☐	☐	Local Aneshetic			

Please List: _____

Do you have any other medical conditions? _____
Are you under medical treatment now? _____
Have you had surgery in the past five years? _____
Do you premedicate or routinely take antibiotics before dental treatment? ☐ Yes ☐ No
Physician's Name _____ Phone _____
Notify in case of emergency _____ Phone _____

I understand the importance of a truthful health history to assist the doctor in providing the best care possible. I have the opportunity to discuss my health history with the doctors and assistants.

X Signature of responsible party _____ Date _____

Seminole Premier DENTAL

Financial Policy

Please read and sign below.

As a courtesy to our patients, our office is happy to file your dental insurance for you and wait up to **30 days** for payment from them. If you prefer, we will collect the full amount due directly from you at the time of service and bill the insurance company for payment to go directly to you.

If you choose to have us wait for your insurance payment, we will collect the amount we **estimate** will be due from you at the time of service. Though we strive to be accurate, this is only an **estimate** and a balance may be due after insurance has paid their portion. After **30 days** or upon payment from you or your insurance company, the balance becomes due and payable in full by you. If a problem arises with the claim or payment, we will continue to do whatever we can for up to **90 days** to see that you are reimbursed any amount still due to you from the insurance company.

Failure to pay your balance within 30 days may result in a late fee of $25.00

Our office policy requires 48 hours notice for rescheduling or canceling an appointment. Failure to do so may/will result in a missed appointment fee.

I have read the agreement above and understand the terms. I choose to have payment paid to the provider of service.

_____

Signature

I choose to pay the full amount due at time of service and have any payment from the insurance company come directly to me.

_____

Signature