Premier Dental Esthetics
"Creating Smiles to Last for Miles"
301 W. Huntington Dr., 217, Arcadia Ca 91007
626-445-2536

Patient Information Form

Personal	Spouse's Information
Name:_____	Name:_____
Social Security #:_____ Birthday_____	Social Security #:_____ Birthday_____
Address:_____	Address:_____
City:_____ Zip Code:_____	City:_____ Zip Code:_____
Home Phone:_____	Home Phone:_____
Work Phone:_____	Work Phone:_____
Cellular Phone: _____	Cellular Phone: _____
Preferred way to contract you: ○ Email: ○ Text: ○ Phone (Home, Wk, Cell) Please circle one	Preferred way to contract you: ○ Email: ○ Text: ○ Phone (Home, Wk, Cell) Please circle one
Email Address:_____	Email Address:_____
Occupation:_____	Occupation:_____
Employer:_____	Employer:_____
Address:_____	Address:_____
City:_____ Zip Code:_____	City:_____ Zip Code:_____
Contact Person in Cases of an Emergency_____	Phone:_____

How did you hear about us?_____

Name of Dental Insurance:_____ Group/Plan:_____

Policy Number:_____ Policy Holder: _____Self _____Spouse _____Child

Length of time with this Carrier:_____

Critical Consent

- I acknowledge that I have received from this office the Notice of Privacy Practices that explains my rights as patient.
- I acknowledge that I have received from this office the Dental Materials Fact Sheet, by Dental Board of California.
- I understand that there can be charges for broken appointments and canceled appointment without 48 hours advance notice.
- I authorize the doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate and necessary by the doctor to make a thorough diagnosis and provide treatment.
- I authorize the doctor to use them in presentations, lectures and publications.
- I authorize Premier Dental Esthetic to release any dental/medical or incidental information that may be necessary for either dental/medical care or in processing application for financial benefit.
- I also authorize the Premier Dental Esthetic to examine and provide treatment agreed upon by me and use the appropriate mediation and therapy indicated for each treatment. I understand that using local anesthetic agents embodies a certain risk. Furthermore, I authorize and consent Peter Young DDS Inc to choose and imply such assistance as deemed fit to provide recommended treatment.
- I understand that where appropriate, credit bureau reports may be obtained.
- I certify that all the above information is correct and will inform the office of any changes.
- It is Premier Dental Esthetic procedure to share Protected Health Information with labs, x-rays, consulting specialists. We will call the pharmacy of your choice regarding your prescriptions. We will only exchange minimum necessary Protected Health Information for each transaction

I read and agreed to the Critical Consent.

Patient Name (Please Print) :_____Signature:_____ Date: _____

MEDICAL HISTORY

Legal Name: _____Nickname_____ Date of Birth _____
Name of Physician/and their specialty_____
Most recent physical examination_____Purpose_____
What is your estimate of your general health? Excellent Good Fair Poor

Do You Have or Have You Ever Had:	Yes	No		Yes	No
1. hospitalization for illness or injury?			25. digestive disorders (i.e. gastric reflux)		
2. any allergic reactions to the following?			26. osteoporosis/osteopernia(i.e. taking bisphosphonates)		
- Aspirin, ibuprofen, acetaminophen			27. arthritis		
- Penicillin			28. autoimmune disease		
- Erythromycin			(i.e. rheumatoid arthritis, lupus, scleroderma)		
- Tetracycline			29. glaucoma		
- Codeine			30. contact lenses		
- Local anesthetic			31 head or neck injuries		
- Fluoride			32. epilepsy, convulsions (seizures)		
- Metals (gold, stainless steel)			33. neurologic problems		
- Latex			34. viral infections and cold sore		
- Any other medications_____			35. any lumps or swelling in the mouth		
3. heart problem, or cardiac stent within the last six months			36. hives, skin rash, hay fever		
4. history of infective endocarditits			37. STI/STD/HPV		
5. artificial heart valve, repaired heart defect (PFO)			38. hepatitis (type____)		
6. pacemaker or implantable defibrillator			39. HIV/AIDS		
7. orthopedic implant (joint replacement)			40. tumor, abnormal growth, cancer		
7. rheumatic or scarlet fever			41. radiation therapy		
8 high or Low blood pressure			42. chemotherapy, immunosuppressive medication		
9. a stroke (taking blood thinners)			43. emotional problem		
10. anemia or other blood disorder			44. psychiatric treatment		
11. prolonged bleeding due to a slight cut			45. antidepressant medication		
12. emphysema, shortness of breath, sarcoidosis			46. Alcohol/drug dependency		
14. tuberculosis, measles, chicken pox			**ARE YOU:**		
15. asthma			47. Presently being treated for any other illness		
16. breathing or sleep problem (.Snoring, sinus, sleep apnea)			48. aware of a change in your general health in the last 24 hrs		
a. If yes to 15: Are you being treated for sleep apnea			(i.e. fever, chills. New cough, or diarrhea)		
b. If yes to 15a: Do you have a CPAP or oral appliance			49. taking medication for weight management		
17. kidney disease			50. taking dietary supplements		
18. 8iver disease			51. often exhausted or fatigued		
19. jaundice			52. experience frequent headaches		
20. thyroid or parathyroid disease			53. a smoker or smoked previously or use smokeless tobacco		
21. hormone deficiency			54. considered a touchy person		
22. high cholesterol or taking statin drugs			55. often unhappy or depressed		
23. Diabetes (What is your A1C? _____)			56. FEMALE—taking birth control pill		
24 stomach or duodenal ulcer			57. FEMALE-are you currently Pregnant		
			58. MALE-prostate disorders		

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment.

_____

List all medications, supplements, and or vitamins taken within the last two years

Medication/Supplement	Reason for taking it	Medication/Supplement	Reason for taking it
1.		5.	
2.		6.	
3.		7.	
4.		8.	

Please use the back side of this page if you are taking more than 8 medications

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATION YOU MAY BE TAKING.

Patient's Signature_____ Doctor's Signature_____ Date_____

Annual Update: (If all above are the same, please write no changes)	Patient's Signature	Doctor's Signature	Date

ASA I II III IV V VI

DENTAL HISTORY

Patient Name:_____

Referred by _____How would you rate the condition of your mouth? Excellent Good Fair Poor

Previous Dentist _____How long have you been a patient? _____Months/Years

Date of most recent dental exam_____/_____/_____Date of most recent x-rays_____/_____/_____

Date of most recent treatment (other than a cleaning)_____/_____/_____

I routinely see my dentist every: 3 Mo. 4 Mo. 6 Mo. 12 Mo. Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

	Yes	No
PERSONAL HISTORY		
1. Are you fearful of dental treatment? Scale of 1 to 10 (Not) 1 2 3 4 5 6 7 8 9 10 (Very)		
2. Have you had an unfavorable dental experience?		
3. Have you ever had complications from past dental treatment?		
4. Have you ever had trouble getting numb or reactions to local anesthetic?		
5. Did you ever have braces, orthodontic treatment or had your bite adjusted?		
6. Have you had any teeth removed or missing teeth that never developed?		
GUM AND BONE		
7. Do your gums bleed when brushing flossing or eating?		
8. Have you ever been treated for gum disease or been told you have lost bone around your teeth?		
9. Have you ever notice an unpleasant taste or odor in your mouth?		
10. Is there anyone with a history of periodontal disease in your family?		
11. Have you ever experienced gum recession?		
11. Have you ever had any teeth become loose on their own (without an injury) or do you have difficulty biting into an apple?		
13. Have you experienced a burning or painful sensation in your mouth not related to your teeth?		
TOOTH STRUCTURE		
14. Have you had any cavities within the past 3 years?		
15. Does the amount of saliva in your mouth seem to little or do you have difficulty swallowing any food?		
16. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth?		
17. Are any teeth sensitive to hot, cold, biting or sweets or avoid brushing any part of your mouth?		
18. Do you have grooves or notches on your teeth near the gum line?		
19. Have you ever had broken teeth, chipped teeth, or had a toothache or cracked filling?		
20 Do you frequently get food caught between any teeth?		
BITE AND JAW JOINT		
21. Do you have problems with your jaw joint? (Pain, sounds, limited opening, locking, popping)		
22. Do you feel like your lower jaw is being pushed back when you bite your teeth together?		
23. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods?		
24. Have your teeth changed in the last 5 years, become shorter, thinner or worn?		
25. Are your teeth becoming more crooked, crowded, or overlapped?		
26. Are your teeth developing spaces or becoming looser?		
27. Do you have more than one bite, squeeze, or shift your jaw to make your teeth fit together?		
28. Do you place your tongue between your teeth or close your teeth against your tongue?		
29. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits?		
30. Do you clench your teeth in the daytime or make them sore?		
31. Do you have any problems with sleep (i.e. restlessness), wake up with a headache or an awareness of your teeth?		
32. Do you wear or have you ever worn a bite appliance?		
SMILE CHARACTERISTICS		
33. Is there anything about the appearance of your teeth that you would like to change?		
34. Have you ever whitened (bleached) your teeth?		
35. Have you felt uncomfortable or self conscious about the appearance of your teeth?		
36. Have you been disappointed with the appearance of previous dental work?		

Patient's Signature_____Doctor's Signature_____Date_____

Premier Dental Esthetics, Office of Peter Young DDS FAGD, 301 W. Huntington Dr. Suite 217, Arcadia, Ca, 91007. Tel 626-445-2536.

FINANCIAL AGREEMENT

Premier Dental Esthetics
301 W. Huntington Dr. Suite 217, Arcadia, CA 91007

The practice is committed to providing optimal treatment for our patients based on a diagnosis of what is in the best interest of their dental and overall health and well-being.

1. PAYMENT IN FULL IS DUE AT THE TIME OF SERVICE.
2. WE ACCEPT *CASH, CHECK, VISA/MASTERCARD, DISCOVER, AMERICAN EXPRESS & CARE CREDIT.*
3. APPOINTMENTS CANCELLED LESS THAN 48 BUSINESS HOURS ARE SUBJECT TO A BROKEN APPOINTMENT FEE.
4. WE WILL PREPARE & SUMIT CLAIMS FOR APPLICABLE PPO/DPO DENTAL INSURANCE.
5. NO SERVICE CAN BE SUBMITTED TO HMO/DMO INSURANCE PLANS, MEDICARE, DENTI-CAL, And OTHER SIMILAR PROGRAMS. MEDICAL INSURANCE MAY COVER CERTAIN PROCEDURES; WE WILL PROVIDE ASSISTANCE FOR YOU TO SUBMIY CLAMIS IF YOU HAVE A PPO MEDICAL INSURANCE PLAN.

Please be prepared to make payment at the time of your appointment. Any alternate arrangements must be made with the front desk prior to your appointment. An account is deemed delinquent if payment is not received in accordance with this policy or separate mutually agreed upon arrangement. Delinquent accounts are subject to a finance charge of 18% APR (regardless of insurance) and no further treatment can be scheduled until the balance is resolved. You agree to pay all legal expenses necessary for the collection of any debt.

_____ Intial Here

Checks are accepted with proper identification. There is a returned check fee of $35 and Alternate means of payment may be required for future charges. A Broken Appointment fee of $50 is applicable to any appointments not cancelled or rescheduled with a team member at least 48 hours prior to the appointment time.

_____ Intial Here

If you have a PPO/DPO Dental Insurance Plan, we will prepare and submit claims provided you complete the Insurance Agreement with valid information with the understanding that you are responsible for payment of services rendered. Your estimated patient portion is due at each visit. Once your insurance has made payment to our office (Assignment to Doctor), or 31 days from the date of submission, any remaining balance will be charged to your credit card on file.

_____ Intial Here

If you do not maintain a credit card on file, any remaining balance must be paid within30 days of the insurance payment, or 31 days from the date of submission, or you may forfeit your Assignment to Doctor Status in which case you will be asked to make payment in full when services are rendered and be reimbursed by your insurance company.

_____ Intial Here

If you have medical insurance, please read the back of this form, initial where appropriate, sign and date. HMO's, Medicare, and similar programs will not reimburse and cannot be billed for services rendered in this office. If you are covered by Medicare please check the box on the back of this form, read thoroughly, sign and date.

_____ Intial Here

Flexible Spending/Savings Accounts vary greatly. It is your responsibility to know the requirements of your plan request documentation in a timely manner and meet your deadlines. We can only run cards in your presence and reversals of charges cannot be handled by our office.

_____ Intial Here

By having services rendered you agree that you are ultimately responsible for all charges incurred. This agreement applies to any patient for whom you are the account guarantor and supersedes all prior agreements signed. In the event that financial responsibility changes, you understand that you remain financially responsible until a new agreement is signed and accepted by our office.

_____ Intial Here

A deposit of 25% the cost of the treatment will be requested when long (more that 90 minutes) appointments are made. This deposit will be a credit for the scheduled treatment. However, this deposit will be non-refundable when the appointment is broken with less that 48 hours prior to the scheduled appointment.

_____ Intial Here

There can be a $100 charge on broken dental hygiene visit and visits that are less that 90 minutes. If that is a charge of schedule, we would appreciate a 48hours notice or it will be considered a broken appointment.

_____ Intial Here

Patient Name (if other than Guarantor) Guarantor Name Social Security # Driver's License #

Signature of Account Guarantor_____ Date:_____

CREDIT CARD ON FILE:" I AUTHORIZE Premier Dental Esthetics, Dr. Peter Young's office to charge this credit card in accordance with the above agreement and the cost amount of treatment/s to be provided.

Credit Card: AmEx Visa Master Discover CC#_____SC _____ Exp Date:_____

Card Holder's Signature:_____ Date:_____