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 doctors 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 Premier Dental Esthetic to examine and provide treatment agreed upon by me and use the appropriate medication 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 when 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 Ever had:	Yes	No		Yes	No
1. hospitalization for illness or injury?			25. digestive disorders (i.e. celiac disease, gastric reflux, bulimia, anorexia)		
2. an allergic reaction to the following?			26. osteoporosis/osteopenia or ever taken anti-resorptive medication (i.e. bisphosphonates)		
- aspirin, ibuprofen, acetaminophen			27. arthritis or gout		
- penicillin, erythromycin			28. autoimmune disease		
- sulfa			(i.e. rheumatoid arthritis, lupus, scleroderma)		
- tetracycline			29. glaucoma/cataract		
- codeine			30. wear contact lenses		
- local anesthetic			31 head or neck injuries		
- fluoride or SLS			32. epilepsy, convulsions (seizures)		
-chlorhexidine (CHX)			33. neurologic disorders (ADD/ADHD, prion disease)		
- metals (gold, nickel, stainless steel)			34. viral infections and cold sore		
- latex			35. any lumps or swelling in the mouth		
-nuts, fruit, milk or shellfish			36. hives, skin rash, hay fever		
- red dye			37. STI/STD/HPV		
- other (please specify)			38. hepatitis (type ___)		
3. heart problem, or cardiac stent within the last six months			39. HIV/AIDS		
4. history of infective endocarditis			40. tumor, abnormal growth, cancer		
5. artificial heart valve, repaired heart defect (PFO)			41. radiation therapy		
6. pacemaker or implantable defibrillator			42. chemotherapy., immunosuppressive medication		
7. orthopedic or soft tissue implant (i.e. joint replacement, breast implant)			43. emotional difficulties		
8. heart murmur, rheumatic or scarlet fever			44. psychiatric treatment or antidepressant medication		
9 high or low blood pressure			45. concentration problems or ADD/ADHD diagnosis		
10. stroke (taking blood thinners?)			46. alcohol/recreational drug use		
11. anemia or other blood disorder			47. speech difficulties or delayed growth at any time		
12. prolonged bleeding or easily bruised			**ARE YOU?**		
13. emphysema, shortness of breath, sarcoidosis			48. presently being treated for any other illness		
14. tuberculosis, measles, chicken pox			49. aware of a change in your general health in the last 24 hrs		
15. breathing problems (i.e. asthma, stuffy nose, sinus congestion)			(i.e. fever, chills, new cough, or diarrhea)		
16. sleep problems (i.e. sleep apnea, snoring, insomnia, restless sleep, bedwetting)			50. taking medication for weight management		
a. If yes to 16: Are you being treated for sleep apnea?			51. taking dietary supplements		
b. If yes to 16a: Do you have a CPAP or oral appliance?			52. often exhausted or fatigued		
17. kidney disease			53. experience frequent headaches or chronic pain		
18. liver disease or jaundice			54. a smoker or smoked previously or use smokeless tobacco		
19. vertigo (i.e." the room is spinning")			55. considered a touchy/sensitive person		
20. thyroid or parathyroid disease or calcium deficiency			56. often unhappy or depressed		
21. hormone deficiency or imbalance (i.e. poly cystic ovarian syndrome)			57. taking birth control pill		
22. high cholesterol or taking statin drugs			58. currently pregnant		
23. diabetes (What is your HbA1c=_____)			59. diagnosed with a prostate disorder		
24. stomach or duodenal ulcer					

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment. (i.e. Botox, Collagen injections)_____

_____

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 (7-2020) Premier Dental Esthetic

Patient Name: _____

What is the most important thing to you about your dental visit today? _____

What is the most important thing to you about your future dental health and or smile? _____

How would you rate the current condition of your mouth (Poor) 1 2 3 4 5 6 7 8 9 10 (Excellent)

How important is your dental health to you? (Not) 1 2 3 4 5 6 7 8 9 10 (Very)

Name of your Previous Dentist _____How long were you a patient? _____Months/Years

Date of most recent dental exam____/___Date of most recent x-rays____/____. I see my dentist every: 3 Mo. 6 Mo. 12 Mo. Not routinely

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 any reactions to local anesthetic?		
5. Did you ever have braces, orthodontic treatment or had your bite adjusted and at what age?		
6. Have you had any teeth removed or missing teeth that never developed? Or lost teeth due to injury or facial trauma?		
GUM AND BONE		
7. Do your gums bleed sometimes or are they ever painful when brushing or flossing?		
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, or can you see more of the roots of your teeth?		
12. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating 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 do you 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 back teeth together?		
23. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods?		
24. In the past 5 years, have your teeth changed (become shorter, thinner or worn)? Or has your bite changed?		
25. Are your teeth becoming more crooked, crowded, or overlapped?		
26. Are your teeth developing spaces or becoming looser?		
27. Do you have trouble finding your bite, or need to squeeze, tap your teeth together, 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 or grind your teeth together in the daytime or make them sore?		
31. Do you have any problems with sleep (i.e. restlessness or teeth grinding), 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 mouth (smile, lips, teeth, gums) that you would like to change? (shape, color, size, display)?		
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_____

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 & SUBMIT 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 within 30 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

Most treatments performed in our office will not be covered by your medical insurance. However, procedures such as but not limited to Sleep related treatments, can be claimed thru medical insurance. Since we are not a medical office, all reimbursement will be directly paid to you. Therefore, payments for all procedures are made at the time of service and as a courtesy, we will send the claim to your medical insurance for direct reimbursement.

_____ 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 than 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.

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:_____