**PREMIER DENTAL CARE**
*DR. MICHAEL SOBOL*
2730 HANOVER PIKE
MANCHESTER, MD 21102
410-374-4882

*Since the cause of dental disease is a combination of many factors, and is very complex, it is necessary to investigate any possible contributing influences. The success of your treatment depends on the control of all causative factors. Please answer all the questions to the best of your ability. All responses are confidential.*

Patient's Name: _____ Date: _____

Home Address: _____

Home Phone: ( ) _____ Work Phone: ( )_____ Cell Phone: ( ) _____

Best Daytime #: ❑Home ❑Work ❑Cell ❑Minor ❑Single ❑Married ❑Divorced ❑Widow

E-mail Address: _____ Referred by: _____

Birth Date: _____ SSN: _____ College Student: ❑ Yes ❑ No ***(Please present student ID)***

Employer's Name: _____ Occupation: _____

In Case of Emergency, contact: _____ Phone Number: _____

**RESPONSIBLE PARTY FOR ACCOUNT** ***(If different from above)***
Name: _____ Relationship to Patient: _____ Birth Date: _____
Address: _____
Home Phone: ( )_____ Work Phone: ( )_____ Cell Phone: ( )_____
Best Daytime #: ❑ Home ❑Work ❑Cell Employer: _____ SSN: _____

**PRIMARY INSURANCE INFORMATION**
Policy Holder: _____ SSN/ID #:_____ Birth Date: _____
Employer: _____Insurance Company: _____ Group: _____

**MEDICAL HISTORY**
1. Are you under the care of a Physician? □ Yes □ No If so, explain? _____
Name: _____ Phone: _____ Last visit: _____

2. What medications, vitamins or herbal remedies are you currently taking? _____

_____

_____

3. Do you smoke or use tobacco products? ❑Yes ❑ No How much? _____ How often? _____

| | | | |
|---|---|---|---|
| ❑ Acid Reflux | ❑ Diabetes | ❑ Kidney Problems | ❑ Tumor(s)/Growth(s) |
| ❑ Allergies (seasonal) | ❑ Dizziness/Light Headed | ❑ Liver Problems | ❑ Venereal Disease(s) |
| ❑ Alcohol Abuse | ❑ Eating Disorder(s) | ❑ Low Blood Pressure | ❑ Yellow Jaundice |
| ❑ Anemia | ❑ Emphysema | ❑ Pace Maker | ❑ Heart Condition |
| ❑ Arthritis | ❑ Endocarditis | ❑ Radiation Therapy | ❑ Fever Blist/Cold Sores |
| ❑ Artificial Joints | ❑ Epilepsy | ❑ Seizures | **Drug Allergies** |
| ❑ Artificial Heart Valve | ❑ Excessive Bleeding | ❑ Sickle Cell Disease | ❑ Aspirin |
| ❑ Asthma | ❑ Fainting | ❑ Sinus Problems | ❑ Codeine |
| ❑ Breathing Problems | ❑ Frequent Headaches | ❑ Sleep Apnea | ❑ Dental Anesthetic |
| ❑ Bruise Easily | ❑ Glaucoma | ❑ Stomach Problems | ❑ Erythromycin |
| ❑ Cancer | ❑ Hepatitis A, B, C | ❑ Stroke | ❑ Jewelry/Metals |
| ❑ Chemotherapy | ❑ High Blood Pressure | ❑ Shortness of Breath | ❑ Latex |
| ❑ Chest Pain | ❑ High Cholesterol | ❑ Serious Illness(s) | ❑ Penicillin |
| ❑ Congenital Heart Defect | ❑ HIV+/AIDS | ❑ Thyroid Problems | ❑ Sulfa Drugs |
| ❑ Depression/Anxiety | ❑ Illegal Drug Use | ❑ Tuberculosis | ❑ Tetracycline |
| **FEMALES**: Pregnant ❑ Yes ❑ No # weeks: _____ | | ❑ Birth Control Pills | ❑ Breast Feeding |

**DENTAL HISTORY**

1. Are your gums swollen and/or irritated? □ Yes □ No

2. Does your jaw ever click and/or pop on opening or closing? □ Yes □ No

3. Have you ever had any serious problems associated with previous dental treatment? □ Yes □ No
   If so, explain _____

**Please check any of the following that apply to you:**

- □ Sensitivity (hot, cold, or sweets)
- □ Headaches, earaches, neck pain
- □ Jaw joint pain
- □ Broken teeth or fillings
- □ Bleeding, swollen or irritated gums
- □ Loose, tipped or shifting teeth
- □ Bad breath or taste

**"If I could change my smile, I would"**

- □ Make them whiter
- □ Make them straighter
- □ Close the spaces in between them
- □ Replace black metal fillings with tooth colored fillings
- □ Repair chipped teeth
- □ Replace missing teeth
- □ Replace old crowns that do not match
- □ Have a smile makeover

***Do you have any dental disease(s), condition(s) or problems not listed above that we should know about? If so, explain*** _____

**Do you have or have you had any of the following:**

- □ Implants
- □ Full Dentures
- □ Partial Dentures
- □ Braces
- □ Gum Treatments

**On a scale of 1 to 10, with 10 being the highest rating:**

How important is your dental health to you?
**1 2 3 4 5 6 7 8 9 10**

Where would you rate your current dental health?
**1 2 3 4 5 6 7 8 9 10**

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

_____
_____
_____
_____

**Please share the following dates:**

Your last hygiene visit: _____/_____

Your last oral cancer screening: _____/_____

Your last complete x-rays: _____/_____

Previous dentist: _____

City: _____ State: _____

_____ _____
Patient's Signature Date

_____ _____
Clinician's Signature Date

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

_____
_____
_____

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# Financial Policy

Thank you for choosing our practice for your dental care. Our team is committed to your overall health and the success of your treatment. Please understand that payment of your bill is considered a part of your commitment to treatment. Just as we are committed to providing you with the very best dentistry has to offer, we are also committed to making dentistry financially comfortable for you as well. Please take the time to read the following, initial each section, and sign & date the bottom of this form.

_____ We will review the estimated cost of treatment as well as review your payment options before treatment begins. We accept Cash, Checks, Visa, MasterCard, and Discover. We also work with CareCredit and Lending Club for patients that need to make monthly payments. **Please note that the processing fees associated with CareCredit and Lending Club are non-refundable.*

_____ As a courtesy, we will accept assignment of your insurance benefits and file your primary insurance claims. However, we do require payment in full of your co-pay and deductible at the time you receive treatment. It is important to understand that your insurance benefits are negotiated between your employer and your insurance company.

_____ As a result some, or perhaps all of the treatment provided may not be covered by your insurance. The cost of these procedures will be your responsibility. Please be aware that some insurance carriers will not allow you to assign your benefits to our office. In those cases, payment is due in full at the time of the visit and your insurance company will reimburse you directly.

_____ Due to the extensive amount of time our staff and doctors devote to preparing and reserving time for your treatment, reservations of 1 hour or longer will require a deposit of half of the treatment fee to make your reservation, which will include a $50.00 non-fundable deposit should the appointment be missed or cancelled with less than 48-hour's notice.

_____ Full payment is due at the time your receive treatment unless arrangements have been made ***prior*** to the start of any procedure.

_____ Patients are asked to confirm their appointments at least 48 hours in advance by directly contacting our office or by responding to our confirmation contact. Failing to confirm your appointment may result in the loss of your reservation and a possible charge for the time reserved.

_____ Appointments that are missed and/or cancelled with less than 48-hour's notice may require a future reservation fee prior to being rescheduled

_____ There will be a fee of $35.00 for any checks returned a Non-Sufficient Funds (NSF)

_____ Patient balances that go unpaid for 30 days or more may incur one or more of the following charges:

- Interest charge of 1.5% per month
- 18% APR collections fees (up to 25% of the full balance)
- Legal fees or Collection Services
-

***I authorize payment to be made directly to Premier Dental Care by my insurance company. I accept full financial responsibility for all services performed in this office. I acknowledge that I have received and reviewed the Office Policies.***

_____ _____

Patient Signature Date

# Premier Dental Care

Michael Sobol, DDS
2740 Hanover Pike
Manchester, MD 21102
410.374.4882

## Acknowledgement of Receipt

**Notice of Privacy Practices**
Our practice is committed to securing the privacy of your health information. Accordingly, we have posted our practice's Notice of Privacy Practices in the reception area. You are not required to read this notice. We would, however, like your acknowledgement that you have been notified that the notice is available for your review. You may request a paper copy of the notice by asking any of our team members.

Patient Name: _____

Signature:_____

Date:_____

An attempt was made to obtain written acknowledgement of receipt of our privacy practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented obtaining acknowledgement
- ☐ Other (please specify)_____
  _____
  _____

**Team Member's Name:** _____

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# Website and Social Media Release

Patient's Name (Please Print): _____

Premier Dental Care, on occasion, take photos and/or videos of patients to be used in our office, for our website (www.PremierDentalCare.net), Facebook, Twitter, Instagram, newsprint and/or related publications. This list is not inclusive, but serves to demonstrate situation is which patients may be photo'd or filmed.

*Please Check One Below:*

_____I give permission to Premier Dental Care to display my photo(s) or video(s) in association with Premier Dental Care events, functions and/or publications

_____I do NOT give permission to Premier Dental Care to display and/or post my photo(s) or video(s) in association with Premier Dental Care events.

_____ _____
Signature of Patient: Date

_____ _____
If patient is under 18 years of age – Signature of Patient's Parent/Legal Guardian Date