Premier Dental Group

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2905 Dudley Ave • Parkersburg, WV 26101

(304)424-5002

Welcome to Premier Dental Group!

***All New Patients please fill out the entire form.**

***Returning patients please review your information and make any necessary changes.**

Chart#: _____ FOR OFFICE USE ONLY

Patient Name: _____ * _____ * ____ _____
Last First MI Preferred Name

Title: _____ **Gender:*** ◯ Male ◯ Female ◯ Other **Family Status:*** ◯ Married ◯ Single ◯ Child ◯ Other
Mr/Ms/Mrs/etc

Birth Date:* _____ **SS#:** ___-__-____ **Prev. Visit:** _____

Email Address: _____ **Best time to call:** _____

Phone: _____ * _____ _____ _____ _____ _____
Home Mobile Work Ext Fax Other

Address: _____ * _____
Address 1 Address 2

_____ * ____ * ___-____ *
City State Zip Code

Employer Name:

_____

_____

Name of Previous Dentist

_____

_____

EMERGENCY CONTACT NAME AND PHONE NUMBER: *

_____

_____

Medical Infomation

Indicate which of the following you have had or have at present. By checking the box it will indicate a "Yes" response, leaving blank will indicate a "No" response.

- ☐ *Latex Allergy
- ☐ Anemia
- ☐ Bisphosphonates
- ☐ Cancer
- ☐ Diabetes
- ☐ Fainting
- ☐ Hay Fever
- ☐ Heart Murmur
- ☐ Kidney Disease
- ☐ Other
- ☐ Radiation/Chemo
- ☐ Sinus Problems
- ☐ Thyroid disease
- ☐ Venereal Disease
- ☐ *No Epinephrine
- ☐ Arthritis
- ☐ Blood Disease
- ☐ Chemical Dependency
- ☐ Dizziness
- ☐ Glaucoma
- ☐ Head Injuries
- ☐ Hepatitis
- ☐ Liver Disease
- ☐ Pacemaker
- ☐ Respiratory Problems
- ☐ Smoking/Tobacco
- ☐ Tuberculosis
- ☐ *Pre-Med
- ☐ Artificial Joints
- ☐ Blood Thinners
- ☐ Clindamycin
- ☐ Epilepsy
- ☐ Growths
- ☐ Heart Attack
- ☐ High Blood Pressure
- ☐ Mental Disorders
- ☐ Penicillin Allergy
- ☐ Rheumatic Fever
- ☐ Stomach Problems
- ☐ Tumors
- ☐ Allergies
- ☐ Asthma
- ☐ Bone Density Meds
- ☐ Codeine Allergy
- ☐ Excessive Bleeding
- ☐ HIV
- ☐ Heart Disease
- ☐ Jaundice
- ☐ Nervous Disorders
- ☐ Pregnancy
- ☐ Rheumatism
- ☐ Stroke
- ☐ Ulcers

If any conditions, ALERTS, or PRE-MED not listed or selected above that needs further clarification, please describe below:

_____

_____

_____

List all medications, drugs, pills or herbal remedies, including regular dosages of aspirin.

_____

_____

_____

Appointment Policy

When we schedule your appointment, we are reserving time for your particular needs. When your appointment is made, a room is reserved, your records are prepared, and special instruments are readied for your visit. As a courtesy to you, we offer a reminder/confirmation call the business day before your appointment. We kindly ask that if you must change an appointment, please give 24 hour notice. This courtesy makes it possible to give your reserved time to another patient who would like it. Repeated cancellations or missed appointments will result in the loss of future appointment privileges. A charge will be made for appointments broken or canceled without 24 hours advance notice.

☐ *** By checking this box, I acknowledge that I have reviewed ALL questions/alerts on this questionnaire and had responded accordingly. There are no other medical conditions or medications/allergies that have not been listed. I am aware that I must notify the practice of any future changes.**

Response Date: _____