CARE FOR YOU DENTAL

OFFICE: (702) 765-4018
FAX: (702) 263-4786

ADDRESS:
1597 E WINDMILL LN #100
LAS VEGAS, NV 89123

Today's Date:_____

• PATIENT INFORMATION

Name: Last: _____ **First:** _____ **Middle:** _____ **DOB:** _____

I Prefer to be called_____

Gender: □Male □Female Social Security #_____-_____-_____ **Marital Status: □Single □Married □Divorced □Widowed**

Home Phone #_____ **Work #**_____ **Other #**_____ **Cell #**_____

E-mail Address: _____ **Is it okay to text and/or E-mail you? □Yes □No Initials**_____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Employer: _____ **Occupation:** _____ **Work #**_____

Spouse or Parent's Name: _____ **Employer:** _____ **Work #**_____

Have you or any member of your family been a patient at this office before: □Yes □No

If yes, please give us their name(s):_____

Who may we thank for recommending our office to you? _____

Otherwise, how did you learn about our practice? □Insurance □Internet □Mailer □Yellow Pages □TV-Channel_____**□Other:**_____

• PRIMARY DENTAL INSURANCE

Insured's Name: _____ **DOB:** _____ **Relationship to Patient:** _____

Social Security #_____-_____-_____ **Member ID:** _____ **Effective Date:**_____

Insurance Carrier: _____ **Phone #:** _____ **Employer:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Group or Policy # _____ **Union/Group Name:** _____ **Local #**_____

• SECONDARY DENTAL INSURANCE

Insured's Name: _____ **DOB:** _____ **Relationship to Patient:** _____

Social Security #_____-_____-_____ **Member ID:** _____ **Effective Date:**_ _____

Insurance Carrier: _____ **Phone #:** _____ **Employer:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Group or Policy # _____ **Union/Group Name:** _____ **Local #**_____

• RESPONSIBLE PARTY

Person responsible for Account:_____**Currently a patient in our office(s)? □Yes □No**

Social Security #_____-_____-_____**DOB:** _____**Drivers License:** _____**State:**_____

Home Phone #_____ **Cell #**_____ **Other #**_____ **Email:**_____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

- To maintain our records up-to-date, this form must be completed every 6 months -

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MEDICAL HISTORY

Please check "Yes" or "No" to all questions below.

Yes	No	
☐	☐	Any change in your health within the last year? _____
☐	☐	Have you been told to take premedication/antibiotics before a dental treatment?
		If yes, for what reason? _____
☐	☐	Hospitalized or a serious illness within the last 5 years? _____
☐	☐	Being treated by a physician now? For what? _____

Do you have or have you ever had?

Yes	No	
☐	☐	Shortness of breath
☐	☐	Sinus Problems
☐	☐	Asthma
☐	☐	Emphysema
☐	☐	Tuberculosis
☐	☐	Sleep apnea/snoring
☐	☐	High Blood Pressure
☐	☐	Heart Murmur / congenital heart disease
☐	☐	Stroke
☐	☐	Heart Attack or any other heart problems
☐	☐	Pacemaker / Prosthetic Heart Valve
☐	☐	Chest Pain
☐	☐	Anemia
☐	☐	Bleeding problem
☐	☐	HIV positive/AIDS/ARC
☐	☐	Hepatitis A B or C / Liver Disease
☐	☐	Stomach problem/ulcer
☐	☐	Diabetes
☐	☐	Kidney/bladder-disease
☐	☐	Thyroid/adrenal disease
☐	☐	Herpes/Cold sore/ fever blister
☐	☐	Human papillomavirus

Yes	No	
☐	☐	Seizures
☐	☐	Dizziness, fainting
☐	☐	Depression / Anxiety
☐	☐	Surgeries (Specify:_____)
☐	☐	Artificial Joint Replacement & Implants
☐	☐	Cancer
☐	☐	Radiation
☐	☐	Chemotherapy

Women Only:

Yes	No	
☐	☐	Are you pregnant? Due Date_____
☐	☐	Do you take birth control pills?
☐	☐	If pregnant, has your doctor cleared you for any possible dental work needed?

Do you take or have you ever taken:

Yes	No	
☐	☐	Recreational drugs
☐	☐	Alchohol
☐	☐	Tobacco in any form
☐	☐	Fosamax/ Osteoporosis meds
☐	☐	Contraception/birth control
☐	☐	Vitamins

Do you have or have you had any other medical problems not listed above? _____

_____

DO YOU HAVE ANY ALLERGIES?

☐ Yes ☐ No

If yes, please list below:

DO YOU CURRENTLY TAKE ANY MEDICATIONS?

☐ Yes ☐ No

If yes, please list below:

DENTAL HISTORY

Do you have any of the following problems?

- ☐ Sensitivity (hot, cold, sweet)
- ☐ Tooth pain or discomfort when chewing
- ☐ Headaches, earaches, jaw joint, neck pain
- ☐ Dry mouth, difficulty swallowing
- ☐ Teeth or filling breaking
- ☐ Grinding or clenching teeth
- ☐ Bleeding, swollen or irritated gums
- ☐ Loose, tipped or shifting teeth
- ☐ Bad breath or bad taste in your mouth
- ☐ Sleep apnea, snoring

Do you have or have you had any of the following?

- ☐ Dentures/Partial dentures
- ☐ Braces
- ☐ Periodontal (gum) treatments

Do you smoke or chew tobacco? How much?

Why did you leave your previous dentist?

If you could change your smile, you would:

- ☐ Make them whiter and brighter
- ☐ Make them straighter
- ☐ Close spaces
- ☐ Replace black metal fillings w/tooth colored fillings
- ☐ Repair chipped teeth
- ☐ Replace missing teeth
- ☐ Replace old crowns that don't match
- ☐ Have a smile makeover

Please rate on a scale of 1-10 (10 is highest):

How important is your dental health to you?

1 2 3 4 5 6 7 8 9 10

Where is your current dental health?

1 2 3 4 5 6 7 8 9 10

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

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

Patient Signature (Guardian if a minor) *Date*

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FINANCIAL POLICY AND AGREEMENT

It is our pleasure to welcome you to our practice. We aim for you to attain optimal oral health by providing you the highest quality of dental care.

In order to do so, we need you to read and understand the following polices implemented in our office. We are here to answer any questions you may have regarding your insurance benefits and fees.

Insurance:
Your insurance is a contract between you and your insurance company. If we are a participating provider for your dental insurance, as a courtesy to you, we will verify your eligibility, estimate your insurance benefit and file your insurance claim for you. However, even though we help our patients with these services, it is your responsibility to know the eligibility of your benefits.

Please understand that we can only estimate what the insurance company will pay for a claim by the eligibility we obtain from them. There may be times when the insurance does not cover the whole cost of the service. If that is the case then, you will be responsible to pay any amount still due on your account after your insurance company has paid the claim. If there is a credit on your account after the Insurance payment, this amount will be refunded to you or remain as a credit on your account for future treatment, as your choice.

Payments:
Our goal is to provide our patients with the best service and quality care possible. Patients who do not have insurance, we request you to pay at the time the service is rendered.

Our team will be happy to assist you with making financial arrangement using care credit or our In-House Discount Plans. We accept cash, Visa Mastercard and Discover.

If you are a patient with dental insurance, full payment of the estimated fees are due at the time of service for the specific treatment that day. If your insurance only covers a portion of the the treatment fees, you must pay the estimated amount of your portion on day of the service.

Estimates:
We will give you a cost estimate before treatment is rendered. We will try to insure that the cost estimate is complete and accurate. However, there are circumstances when it becomes impossible to know exactly what treatment needs to be performed. Sometimes the dental condition requires less treatment, in which case your treatment fees will be less than estimated. Other times, the dental condition requires more treatment than initially anticipated, in which case your treatment fees will be more than estimated. If more treatment is required than initially estimated, you will be informed of the treatment required and fees before the additional treatment is performed.

Broken Appointment:
When you book an appointment with us, that time is reserved specially for you with appropriate length of time to give you the quality care you deserve. By not rescheduling the appointment at least 48 business hours before your appointment time, we miss the opportunity to help another patient in that time slot. Appointments that are missed or not rescheduled or cancelled 48 hours (Business Days) before the appointment time will be subject to a charge of $50 dollars.

Patient Signature:_____Date:_____

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Authorization for Release of Photographs:

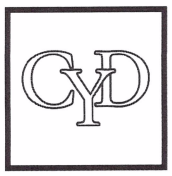
I consent Care For You Dental to take photographs, slides videos of me. I Understand that photographs, slides and videos of my teeth, jaws and face will be used as a record of my care and may be used for communication with other health care professionals and / or business associates eg: dental labs.

The content may also be used for the publicity or advertising purposes (eg: website publications, facebook posts etc) to benefit the practice.

I further understand that if the photographs, slides, and videos are used in any publication or as a part of a demonstration, my identifying information (first name only) could be used unless stated differently below. I do not expect compensation, financial or otherwise, for the use of these photographs.

This consent can be revoked at any time with a request to do so in writing.

Signature_____Date:_____



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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessment and physician certifications

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operation. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason: