HEALTHY SMILES
LAS VEGAS

Patient Information

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)

SS#: _____ Birth date: _____ Age_____

Gender: M ☐ F ☐ Family Status: Single ☐ Married ☐ Other ☐

Address: _____
Street Apartment #

_____
City State Zip Code

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

Email address: #: _____

How did you hear about our office?

☐ Yellow pages ☐ ☐ yelp ☐ Google ☐ Family/Friend Name: _____ ☐ Other_____

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____
Street City, State Post Code Phone

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID/SS #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

_____

Secondary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID/SS #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

_____

_____ Date: _____
Signature of patient, parent or guardian

Dental History

Reason for today's visit _____

Date of las dental visit _____ *Last dental cleaning* _____

Are you dissatisfied with the appearance of your teeth? ❑ YES ❑ NO
Please Explain: _____

Would you like for your teeth to be <u>whiter</u>? ❑ YES ❑ NO

Check(√) if you have any of the following

☐ Bad breath	☐ Food collection between the teeth	☐ Mouth breathing /snoring	☐ Sensitivity when biting
☐ Grinding teeth	☐ Pain around ear	☐ Sores or growths in your mouth	☐ Jaw pain or tiredness
☐ Clicking or popping jaw	☐ Gums swollen or bleeding	☐ Loose teeth or broken fillings	☐ Sensitivity to cold /heat
☐ Sensitivity to sweets			

How often do you floss?_____ Howoftern do you brush?_____

MEDICAL HEALTH HISTORY

Do you have or have you had any of the following?
(Please check any that apply)

- ❑ AIDS or HIV positive
- ❑ Anemia or blood disorders
- ❑ Arthritis, Rheumatism
- ❑ Artificial Heart valves
- ❑ Artificial joints
- ❑ Asthma
- ❑ Abnormal bleeding after extractions, surgery
- ❑ Blood Disease
- ❑ Cancer or tumor
- ❑ Chemical Dependency
- ❑ Chemotherapy
- ❑ Circulatory Problems
- ❑ Congenital Heart Lesions
- ❑ Cough, persistent or bloody
- ❑ Diabetes
- ❑ Emphysema
- ❑ Epilepsy, seizures, or fainting spells
- ❑ Glaucoma
- ❑ Migraine headaches or frequent headaches
- ❑ Heart Murmur,
- ❑ Heart Problems
- ❑ Hepatitis or other liver disease
- ❑ Herpes or cold sores
- ❑ High or low blood pressure
- ❑ Kidney disease
- ❑ Liver disease
- ❑ Low blood pressure
- ❑ Mitral valve prolapse, heart defect
- ❑ Neurologic condition
- ❑ Pacemaker
- ❑ Radiation Treatment
- ❑ Respiratory disease
- ❑ Rheumatic fever
- ❑ Scarlet fever
- ❑ Shortness of Breath
- ❑ Sinus trouble
- ❑ Stroke
- ❑ Tuberculosis or other lung problems
- ❑ Tumor or growth on the head or neck
- ❑ Venereal diseases
- ❑ Other:_____

<u>Are you allergic to, or have you reacted adversely to any of the following?</u>

- ❑ Latex materials
- ❑ Penicillin or other antibiotics
- ❑ Local anesthetics ("Novocain")
- ❑ Codeine or other narcotics
- ❑ Sulfa drugs
- ❑ Barbiturates, sedatives, or sleeping pills
- ❑ Aspirin
- ❑ Other:_____

Women:

- ❑ **May be pregnant**
  Expected delivery date: _____
- ❑ **Taking hormones or contraceptives**

Blood pressure _____Date _____

<u>Do you smoke or use chewing tobacco?❑ yes ❑ no</u>

<u>Are you taking any of the following?</u>

- ❑ Aspirin
- ❑ Anticoagulants (blood thinners)
- ❑ Antibiotics or sulfa drugs
- ❑ High blood pressure medicine
- ❑ Antidepressants or tranquilizers
- ❑ Insulin, Orinase, or other diabetes drug
- ❑ Nitroglycerin
- ❑ Cortisone or other steroids
- ❑ Osteoporosis (bone density) medicine
- ❑ Other:_____

Name of your physician:_____

I certify that I have read and understand that above information to the best of my knowledge. The above questions have been accurately answered.
I authorize all procedures necessary in diagnosing my dental treatment.
I authorize my dental insurance company to pay directly to the dentist insurance benefits otherwise payable to me.
I acknowledge receipt of HIPPA privacy laws. I authorize **<u>Healthy Smiles</u>** to release all information necessary to bill and receive payment from my dental insurance company.

_____ _____
Signature of patient (or parent) Date

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LAS VEGAS

FINANCIAL AGREEMENT

PLEASE READ CAREFULLY

THANK YOU FOR CHOOSING HEALTHY SMILES FOR YOUR DENTAL CARE. IN ORDER TO PROVIDE YOU WITH THE BEST SERVICE AND TO MINIMIZE COSTS, ANY FINANCIAL ARRANGEMENTS NEED TO BE MADE PRIOR TO DENAL TREATMENT. PAYMENT IS EXPECTED WHEN SERVICES ARE RENDERED.

AS A COURTESY TO OUR PATIENTS USING DENTAL INSURANCE; WE WILL FILE YOUR INSURANCE CLAIMS FOR YOU. IT IS YOUR RESPONSIBILITY TO PROVIDE US WITH CURRENT INFORMATION AND INFORM US OF ANY CHANGES. PRIOR TO YOUR VISIT, WE WILL ATTEMPT TO CONTACT YOUR INSURANCE COMPANY TO VERIFY COVERAGE AND CHECK CO-PAYMENTS AND DEDUCTABLE AMOUNTS. WE BASE OUR ESTIMATES ON THE INFORMATION WE OBTAIN FROM YOUR INSURANCE COMPANY. IF FOR ANY REASON, YOUR INSURANCE DOES NOT PAY WITHIN 60 DAYS, OR DENIES PAYMENT FOR ANY REASON, YOU WILL BE REQUIRED TO PAY THE BALANCE IN FULL. SOME PROCEDURES ARE NOT COVERED BY CERTAIN INSURANCE PLANS. WE RECOMMEND THE TREATMENT THAT IS BEST FOR YOUR ORAL HEALTH. WE DO NOT BASE OUR DIAGNOSIS OR RECOMMENDATIONS ON INSURANCE COVERAGE OR LIMITATIONS.

PLEASE CALL OUR OFFICE 48 HOURS IN ADVANCE WHEN REQUESTING A SCHEDULE CHANGE. WE DO CHARGE A $25.00 FEE FOR MISSED APPOINTMENTS THAT ARE NOT CANCELLED 24 HOURS PRIOR TO THE APPOINTMENT TIME. WE WILL TRY TO CALL AND REMIND YOU OF YOUR APPOINTMENT A DAY BEFORE OR ON FRIDAY IF APPOINTMENT IS ON MONDAY. IF YOU DO NOT RECEIVE A CALL, IT DOES NOT DISMISS YOUR RESPONSIBILITY FOR KEEPING YOUR APPOINTMENT. CONFIRMING YOUR APPOINTMENT IS MERELY A COURTESY WE PROVIDE TO OUR PATIENTS.

I UNDERSTAND THAT I AM ULTIMATELY RESPONSIBLE FOR ALL SERVICES RENDERED. IN CASE OF DEFAULT, I AM RESPONSIBLE FOR THE COST OF COLLECTION PROCEEDINGS (30% OF BALANCE) AND I WAIVE THE RIGHT TO HAVE ANY AMOUNTS OWED DISCHARGED IN BANKRUPTCY. RETURNED CHECKS ARE SUBJECT TO A RETURNED FEE OF $35.00

I HAVE READ THE SBOVE CONDITIONS OF TREATMENT AND PAYMENT AND AGREE TO ITS CONTENT.

SIGNATURE_____**DATE**_____

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GENERAL INFORMED CONSENT

Patient name_____

Examination: I understand that to properly diagnose my oral health, it will be necessary to perform a complete examination and necessary radiographs (x-rays). I understand that holding my mouth open during treatment may leave my jaw feeling stiff and sore and may make it difficult for me to open wide for several days. This can occasionally be an indication of a further problem. I must notify your office if this or other concerns arise.

Proposed treatment plan: I understand that dentistry is not an exact science and therefore I cannot be given guarantees on results. I understand that during treatment it may be necessary to modify or add procedures based on conditions discovered while working on the teeth that were not found during examinations (e.g. root therapy following routine restorative procedures). I will be informed of any change and be given an opportunity to discuss any changes.

Anesthesia: anesthetizing agents are infiltrated into a small area or injected as nerve block directly into a larger area of the mouth with the intent of numbing the area to receive dental treatment. Risks include (not limited to): it is normal for the numbness to take time to wear off after treatment, usually two or three hours. However, it can take longer and rarely the numbness is permanent if the nerve is injured. Infection, swelling, allergic reactions, discoloration, headache, tenderness at the needle site, dizziness, nausea, vomiting, and cheek, tongue, or lip biting may occur. In rare instances patients have a reaction to the anesthetic, which may require emergency medical attention, or find that it reduces their ability to control swallowing. This increases the chance of swallowing foreign objects during treatment. Occasionally, it may take multiple injections to numb the tooth. On rare occasions complete anesthesia cannot be accomplished, and the patient will have to be re-appointed.

Medications: I understand that all medications dentist prescribe have the potential for accompany risks, side effects, and drug interactions. Therefore, it is critical that I tell my dentist of all medications I am currently taking.

Women: because anesthetics, medications and drugs can be harmful to the unborn child and may cause birth defects or spontaneous abortion, every female must inform the dentist if she could be pregnant. Anesthetics, medications and drugs absorbed in the mother's milk may temporarily affect the behavior of the nursing baby. In either case, the anesthesia and treatment may be postponed.

Disputes: Should any dispute arise over dental services provided to me that is allegedly unnecessary, unauthorized, improperly negligent, or incompetently performed, said dispute shall be submitted to Peer Review conducted by the local component of the American Dental Association. The Peer Review decision shall be binding on both parties.

I have had an opportunity to ask questions about the above statements and believe that I have sufficient information to give my consent as noted below.
I have read the above statements, understand, and agree to them.

Patient Signature:_____Date:_____

Dentist Signature:_____Date:_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowedgement*

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
Please Print Name

_____
Signature

_____
Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____

Healthy Smiles Dental – NOTICE OF PRIVACY PRACTICES

This Notice describes how your healthy information may be used and disclosed. Please Read Carefully

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice regarding our privacy practices, our legal duties and your rights concerning your healthy information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 1-1-09, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or, for additional copies of this Notice, please contact us using the information listed at the bottom of this Notice.

USES AN DISCLOSURES OF HEALTH INFORMATION

We use and disclose healthy information about you for treatment, payment and healthcare operations.

Treatment: We may use or disclose your health information to a physician providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing and credentialing activities.

Your Authorization: In addition to our use of your healthcare information for treatment, payment of healthcare operations, you may give us written authorization to use your health information or disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use of disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend, or other person, to the extent necessary to help you with your healthcare or with payment of healthcare, but only if you agree that we may do so.

Persons Involved With Care- We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, we will give you the opportunity to object to such disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment, disclosing only health information that is directly relevant to the persons involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filed prescriptions, medical supplies, x-rays or other similar health information.

Marketing Health Related Services : We will not use information for marketing communications without your written authorization.

Required By Law: We may use your healthy information for marketing with your written permission.

Abuse and Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, domestic violence, or the victim of some other crime. We may disclose your health information to the extent necessary to avert a serious threat to your safety or the health of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other security activities. We may disclose to correctional law enforcement officials having lawful custody of protected health information of an inmate or other person under certain circumstances.

Appointment Reminders : We may use of disclose your health information to provide you with appointment reminders (including voicemail, messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information with limited exceptions. We will provide photocopies of x-rays, patient ledger and treatment plans. You must request your x-rays in writing. You can obtain a copy of the form using the contact information below. Depending on business volume, it may take up to 48 hours to fill your request.

Disclosure Accounting: You have the right to receive a list of instances in which we, or our business, disclosed your health information for purposes other than treatment, payment, healthcare operations, and certain other activities, for the last 6 months, but not before April, 14, 2003. If you request accounting more than once in a twelve month period, we may charge you a reasonable cost based fee for responding to these requests.

Restriction: You have the right to request that we place additional restrictions on our use or a disclosure of your health information. We are not required to agree to these additional restrictions but, if we do, we will abide by our agreement (except in an emergency)

Alternative Communication: You have the right to request that we communicate with you about your health information by alternate means or to alternate locations. You must make your request in writing. You must specify the alternate means or location and provide satisfactory explanation how payments will be handled under the alternate means or locations you request.

Amendment: You have the right to request that we amend access to your health information. Your request must be in writing and must explain why the information must be amended. We may deny your request under some circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic e-mail, you are entitled to a written form at your request.

QUESTIONS & COMPLAINTS

If you want additional information regarding our privacy practices, or, if you are concerned that we may have violated your privacy rights or you disagree with a decision we made regarding access to your health information please contact us. You may also submit a written complaint to the US Department of Health and Human Services. We will provide you with the address to file your complaint upon request. If you choose to file a complaint with Health and Human Services, we support your right and will not retaliate in any way.