Nevada Dentistry & Braces

# Patient Information Form

**Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form. If you have any questions or need assistance, please ask us. We will be happy to help!**

**Today's Date**: _____/_____/_____

Patient: _____ SSN# #: _____
*Last Name* *First Name* *Initial*

Gender: ☐M ☐F Date of birth: _____ ☐*Child* ☐*Single* ☐*Married* ☐*Separated* ☐*Divorced*

Address:_____ Apt# :_____

City: _____ State:_____ Zip Code:_____

State ID/Driver's License #: _____ Email: _____

Home Phone: _____ Cell Phone: _____Work Phone: _____

Employer:_____ Position:_____

Business Address: _____City: _____State: _____ Zip: _____

How did you hear from our office? _____

**Responsible party information:** *if patient is the responsible party for this account you can skip this section.*

Person responsible of Account: _____
*Last Name* *First Name* *Initial*

Relation to Patient: _____ Birthday: _____ SSN #: _____

Address *(If different from patient)*: _____ Apt#: _____

City: _____ State:_____ Zip Code:_____

State ID/Driver's License #: _____State: _____

Employer:_____ Position:_____

Business Address: _____City: _____State: _____ Zip: _____

## Primary Insurance Information:

Insurance Company: _____ Subscriber ID #: _____ Group#: _____

Compony Phone #: _____ Name of employer: _____

Policy holder Name: _____ DOB of policy holder: _____

Policy holder SSN#: _____Relationship to patient: _____

**DO YOU HAVE ADDITIONAL INSURANCE? IF YES PLEASE COMPLETE THE FOLLOWING: (please note: Failure to disclose insurance information constitutes an insurance fraud. A felony in the state of Nevada. NVCC1349.33)**

## Secondary Insurance Information:

Insurance Company: _____ Subscriber ID #: _____ Group#: _____

Contact Phone #: _____ Name of employer: _____

Policy holder Name: _____ DOB of policy holder: _____

Policy holder SSN#: _____Relationship to patient: _____

## Patient medical history:

**Physician:**_____**Phone #**:_____**Date of Last Exam**:_____

**2.** Are you under any medical treatment now? **YES NO (If yes, please explain):** _____.

**3.** Have you ever been hospitalized for any surgical operation or serious illness in the past year?.....**YES NO**
**If yes, please explain**:_____.

**4.** Are you taking any medication(s) Including non-prescription medicine? If yes, please list below:
_____.

**5. Patient Dental History**
-**Name of previous Dentist**:_____**Date of last Exam**:_____.
-**Are you having any pain? Circle pain level that applies: 1 2 3 4 5 6 7 8 9 10**
-**Do you wear Dentures or Partials? If yes, please state the date of placement:**_____.

**6. For women only:**
Are you pregnant?.....**YES NO** Do you think you may be pregnant?.....**YES NO**
Expected Delivery Date:_____. Are you nursing/Breastfeeding?.....**YES NO**

**7. Are you allergic to or have you had any reaction to the following?**
Penicillin or any other Antibiotics.....**YES NO** - **If yes please explain**:_____.
Local Anesthetics(e.g. Novocain).....**YES NO**
Sulfa Drugs.....**YES NO**
Barbiturates.....**YES NO**
Sedatives.....**YES NO**
Iodine.....**YES NO**
NSAID.....**YES NO**
Aspirin.....**YES NO**
Metals.....**YES NO**
Latex rubber.....**YES NO**
Nitrile.....**YES NO**
**Other (please list)**:_____.

**8. Do you use tobacco?**...**YES NO**

**9. Do you use controlled substances?**.....**YES NO**

## 10. Do you have or have you had any of the following?

High Blood Pressure.....**YES NO** **Blood Thinners? YES NO**
Low Blood Pressure.....**YES NO**
Heart attack.....**YES NO** **Date:**_____
Heart problems.....**YES NO**
Heart Murmur.....**YES NO** **Date:**_____
Mitral Valve Prolapse.....**YES NO** **Date**:_____
Cardiac Pacemaker.....**YES NO** **Installed**:_____
Stroke.....**YES NO** **Date:**_____
Fainting.....**YES NO**
Epilepsy/Seizures.....**YES NO**
Easily Winded.....**YES NO**
Frequently Tired.....**YES NO**
Diabetes.....**YES NO**
Arthritis.....**YES NO**
Thyroid Problems.....**YES NO**
Cancer.....**YES NO** **Active? YES NO**
Anemia.....**YES NO**
Radiation Therapy.....**YES NO**
Angina.....**YES NO**
Lupus.....**YES NO**
Liver Disease.....**YES NO**
Kidney Disease.....**YES NO**
Emphysema.....**YES NO**
Tuberculosis.....**YES NO**
HPV.....**YES NO**
Hepatitis.....**YES NO (Type)**: _____.
Jaundice.....**YES NO**
Sexually Transmitted Disease....**YES NO**
A.I.D.S./HIV.....**YES NO**
Recent weight loss.....**YES NO**
Stomach Troubles.....**YES NO**
Asthma.....**YES NO**
Respiratory Problems.....**YES NO**
Chest pains.....**YES NO**
Joint Replacement/Implant.....**YES NO**
Swollen Ankles.....**YES NO**
Glaucoma.....**YES NO**
**Others please list below:**
_____.

**Signature of patient (or parent/guardian if minor):**_____**Date:**_____.

Nevada Dentistry & Braces

**FINANCIAL POLICY**

**4492 S. PECOS RD, LAS VEGAS, NV 89121**
**PH: (702)701-7999 FAX: (702)722-2277**

This is an agreement between Nevada Dentistry & Braces, as a creditor, ad the patient/Debtor named on this form. In this agreement the word "you", "your" and "yours" mean the Insured/Debtor. The word "account" means the account that has been established in your name to which charges are made and credited. The words "we", "us" and "ours" refer to Nevada Dentistry & Braces. By executing this agreement, you are agreeing to pay for all services that are received.

- **PAYMENT OPTIONS IF YOU HAVE NO INSURANCE:**
  A: You choose to pay cash, debit, or credit card on the day of which treatment is rendered. (NO CHECKS)
  B: On treatment involving surgery, the payment is due on or before the day of payment agreement.
  C: We offer special financing through Care Credit, Wells Fargo, HCS, and Green Sky. ASK US HOW TO APPLY!
- **PAYMENT OPTIONS IF YOU HAVE INSURANCE:**
  **A:** You choose to pay your deductible and any out-of-pocket portions at the time services are rendered by cash, debit or credit card. (WE DO NOT ACCEPT CHECKS)
  **B:** If we cannot verify your insurance for any reason, we have no control over, payment for all treatment is expected at the time of service.
  **C:** If your insurance under pays for any claim for what ever reason, you will be responsible to paid that portion.
- **PAYMENTS:** Unless other arrangements are approved by us in writing, the balance on your statement due is payable when the statement is issued, will be past due if not paid by the end of the month.
- **ASEGURANZA:** Insurance is a contract between you and your insurance company. We will bill to your insurance as a courtesy to you. Although we may estimate what your insurance company may pay, it is the company that makes the final determination of your eligibility. You agree to pay portion of the charges not covered by your insurance.
- **PAST DUE ACCOUNTS:** If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all of the collection costs which are incurred. If we have to refer collections of the balance to a lawyer, you agree to pay all lawyer's fees which incur plus court cost.
- **WAIVER OF CONFIDENTALITY:** You understand if this account is submitted to an attorney or collection agency, the fact you received treatment at our office may become a matter of publics record.
- **DIVORCE:** In case of a divorce, the party responsible for the account prior to the divorce or separation remains responsible for those subsequent charges. If divorce decree requires the other parent to pay all or part of the treatment cost, it is authorizing parent's responsibility to collect from the other parent.
- **TRANSFER OF RECORDS:** You will need to request in writing and pay the copay fee of $20.00 if you want copies of your records and x-rays sent to another office.
- **CO-SIGNATURE:** If this or another Financial Policy is signed by another person, that co-signature remains in effect until canceled in writing. If written cancellation is received, it becomes with any subsequent charges.
- **EFFECTIVE DAY:** Once you have signed this agreement, you agree to all of the terms and conditions contained herein and agreement will be in full force and effect.

_____ _____

**Print Patient's Full Name** **Date**

_____ _____

**Signature of Patient, Parent, or Legal Guardian** **Date**

Nevada Dentistry & Braces

**HIPPA COMPLIANCE PATIENT CONSENT FORM**

**4492 S. PECOS RD, LAS VEGAS, NV 89121**
**PH: (702)701-7999 FAX: (702)722-2277**

- Our notice of Privacy Practice Provides information about how we may use or disclose protected health information.
- The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.
- The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.
- You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement.
- The HIPPA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.
- By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

### By signing this form, I understand that:

- ❖ Protected healthcare information may be disclosed or used for treatment, payment, or healthcare operations.
- ❖ The practice reserves the right to change the privacy policy as allowed by law.
- ❖ The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- ❖ The practice has the right to revoke this consent in writing at any time and all full disclosure will then cease.
- ❖ The practice may condition receipt of treatment upon execution of this consent.

### Authorization and Release:

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to the third-party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand and agree with a collection service charge of fifty percent of the outstanding balance which will be added once my account becomes delinquent. An additional fee of one hundred and fifty dollars ($150) will be charged in addition to court fees to cover any small claims for court filings.

- ❖ **May we call, email or send a text to you to confirm appointments? YES NO**
- ❖ **May we leave a message on your answering machine at home or on your cell phone? YES NO**
- ❖ **May we share pictures without name/last name on our website or social media? YES NO**
- ❖ **May we discuss your medical condition with any member of your family? YES NO**
- ❖ **If yes, please list the name of the family members allowed:**

Name:_____ Relationship:_____.

**This consent was signed by:_____.**

**(PRINT NAME PLEASE)**

**SIGNATURE:_____DATE:_____.**

**WITNESS:_____DATE:_____.**

Nevada Dentistry & Braces

**CANCELLATION/NO SHOW POLICY**

**4492 S. PECOS RD, LAS VEGAS, NV 89121**
**PH: (702)701-7999 FAX: (702)722-2277**

## 1. Cancellation / No show Policy for Doctor Appointment

-We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book.

**-If an appointment is not cancelled at least 24 hours in advance you will be charged a Twenty-five-dollar ($25) fee; this will not be covered by your insurance company.**

## 2. Scheduled appointments

-We understand that delays can happen however we must try to keep the other patients and doctor on time. If a patient is 15 minutes past their scheduled time, we will have to reschedule the appointment.

## 3. Cancellation / No show Policy for Treatment

-Due to the large block of time needed for treatment, last minute cancellations can cause problems and added expenses for the office.

-**If treatment is not cancelled at least 24 hours in advanced you will be charged a thirty-dollar ($30) fee; this will not be covered by your insurance company.**

## 4. Account balances

-We will require that patients with self-pay balances do pay their account balances to zero ($0) prior to receiving further services by our practice.

-Patients who have questions about their bills or who would like to discuss a payment plan option may call and ask to speak to a business office representative with whom they can review their account and concerns.

-Patients with balances over $100 must make payment arrangements prior to future appointments being made.

_____ _____.

**Print patient's full name** **Date**

_____ _____.

**Signature of patient, Parent, or Legal Guardian** **Date**