PATIENT INFORMATION (CONFIDENTIAL)

NAME _____ DATE _____
FIRST MI LAST

ADDRESS _____ CITY _____ STATE _____ ZIP _____

E-MAIL _____ CELL PHONE _____ HOME PHONE _____

SS# / SIN _____ BIRTHDATE _____

CHECK APPROPRIATE BOX: [ ] MINOR [ ] SINGLE [ ] MARRIED [ ] DIVORCED [ ] WIDOWED [ ] SEPARATED

IF COLLEGE STUDENT, F.T. / P.T., NAME OF SCHOOL _____ CITY _____ STATE _____

PATIENT'S OR PARENT'S / GUARDIAN'S EMPLOYER _____ WORK PHONE _____

BUSINESS ADDRESS _____ CITY _____ STATE _____ ZIP _____

SPOUSE OR PARENT'S / GUARDIAN'S NAME _____ EMPLOYER _____ WORK PHONE _____

WHOM MAY WE THANK FOR REGERRING YOU? _____

PERSON TO CONTACT IN CASE OF AN EMERGENCY _____

RESPONSIBLE PARTY

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT _____ RELATIONSHIP TO PATIENT _____

ADDRESS _____ HOME PHONE _____

DRIVER'S LICENSE # _____ BIRTHDATE _____ SS# / SIN _____

EMPLOYER _____ WORK PHONE _____

INSURANCE INFORMATION:

The correct information is necessary from the patient to properly file claims. We cannot guarantee benefits and can provide estimates only on your portion of treatment. Unpaid balances may be due from the patient should insurance decline benefits upon review of claims for actual services rendered.

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

BIRTHDATE _____ SS# / SIN _____ DATE EMPLOYED _____

NAME OF EMPLOYER _____ UNION OR LOCAL # _____ WORK PHONE _____

EMPLOYER ADDRESS _____ CITY _____ STATE _____ ZIP _____

INSURANCE CO. _____ TEL # _____ GRP# _____ POLICY # _____

INS. CO. ADDRESS _____ CITY _____ STATE _____ ZIP _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? [ ] YES [ ] NO IF YES, COMPLETE THE FOLLOWING:

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

BIRTHDATE _____ SS# / SIN _____ DATE EMPLOYED _____

NAME OF EMPLOYER _____ UNION OR LOCAL # _____ WORK PHONE _____

EMPLOYER ADDRESS _____ CITY _____ STATE _____ ZIP _____

INSURANCE CO. _____ TEL # _____ GRP# _____ POLICY # _____

INS. CO. ADDRESS _____ CITY _____ STATE _____ ZIP _____

X _____

SIGNATURE OF PATIENT OR PARENT / GUARDIAN IF MINOR

REGISTRATION

PATIENT MEDICAL HISTORY

PATIENT'S NAME_____ DATE OF BIRTH_____

ALTHOUGH DENTAL PERSONNEL PRIMARILY TREAT THE AREA IN AND AROUND YOUR MOUTH, YOUR MOUTH IS A PART OF YOUR ENTIRE BODY. HEALTH PROBLEMS THAT YOU MAY HAVE, OR MEDICATION THAT YOU MAY BE TAKING, COULD HAVE AN IMPORTANT INTERRELATIONSHIP WITH THE DENTISTRY THAT YOU WILL BE RECEIVING. THANK YOU FOR ANSWERING THE FOLLOWING QUESTIONS.

	YES	NO
1. ARE YOU IN GOOD HEALTH	☐	☐
2. HAVE THERE BEEN ANY CHANGES IN YOUR GENERAL HEALTH WITHIN THE PAST YEAR	☐	☐
3. DATE OF YOUR LAST PHYSICAL EXAM		
4. PHYSICIAN'S NAME ADDRESS PHONE NO.		
5. ARE YOU NOW UNDER THE CARE OF A PHYSICIAN	☐	☐
6. HAVE YOU EVER BEEN HOSPITALIZED FOR ANY SURGICAL OPERATION OR SERIOUS ILNESS PLEASE EXPLAIN.	☐	☐
7. ARE YOU TAKING ANY MEDICINE(S)	☐	☐
INCLUDING NON-PRESCRIPTION MEDICINE	☐	☐
IF YES, WHAT MEDICINE(S) ARE YOU TAKING		
8. HAVE YOU HAD ANY ABNORMAL BLEEDING	☐	☐
9. DO YOU BRUISE EASILY	☐	☐

	YES	NO
10. HAVE YOU EVER REQUIRED A BLOOD TRANSFUSION	☐	☐
11. HAVE YOU HAD A RECENT WEIGHT LOSS	☐	☐
12. HAVE YOU EVER TAKEN FEN-PHEN/REDUX	☐	☐
13. DO YOU USE TOBACCO	☐	☐
14. DO YOU OR HAVE YOU USED CONTROLLED SUBSTANCES	☐	☐
15. ARE YOU WEARING CONTACT LENSES	☐	☐
16. DO YOU HAVE A PERSISTENT COUGH OR THROAT CLEARING NOT ASSOCIATED WITH A KNOWN ILLNESS (LASTING MORE THEN 3 WEEKS)	☐	☐
17. DO YOU HAVE ANY DISEASE, CONDITION OR PROBLEM NOT LISTED ABOVE THAT YOU THINK I SHOULD KNOW ABOUT	☐	☐
WOMEN ONLY:		
ARE YOU PREGNANT OR THINK YOU MAY BE PREGNANT	☐	☐
ARE YOU NURSING	☐	☐
ARE YOU TAKING BIRTH CONTROL PILLS	☐	☐

ARE YOU ALLERGIC TO OR HAVE YOU HAD REACTIONS TO:	YES	NO
LOCAL ANESTHETICS LIKE NOVOCAINE	☐	☐
PENICILLIN OR OTHER ANTIBIOTICS	☐	☐
SULFA DRUGS	☐	☐
BARBITURATES, SEDATIVES OR SLEEPING PILLS	☐	☐
ASPIRIN	☐	☐
IODINE	☐	☐
ANY METALS (E.G., NICKEL, MERCURY, ETC.)	☐	☐
LATEX / RUBBER	☐	☐
OTHER (PLEASE LIST)		
DO YOU HAVE OR HAVE YOU EVER HAD THE FOLLOWING:		
RHEUMATIC DISEASE OR RHEUMATIC FEVER	☐	☐
SCARLET FEVER	☐	☐
HEART TROUBLE, HEART ATTACK, OR ANGINA	☐	☐
HEART MURMER	☐	☐
CHEST PAIN	☐	☐
SHORTNESS OF BREATH	☐	☐
PACEMAKER	☐	☐
HEART SURGERY	☐	☐
HIGH/LOW BLOOD PRESSURE	☐	☐
CONGENITAL HEART PROBLEM	☐	☐
SWELLING OF FEET, ANKLES, HANDS	☐	☐
HEPATITIS, JAUNDICE OR LIVER DISEASE	☐	☐
STROKE	☐	☐
SINUS TROUBLE	☐	☐
LUNG OR BREATHING PROBLEMS	☐	☐
ASTHMA OR HAY FEVER	☐	☐
HIVES OR SKIN RASH	☐	☐

	YES	NO
FAINTING OR DIZZY SPELLS	☐	☐
DIABETES	☐	☐
AIDS OF HIV INFECTION	☐	☐
THYROID PROBLEMS	☐	☐
ALLERGIES	☐	☐
ARTHRITIS OR RHEUMATISM	☐	☐
JOINT REPLACEMENT OF IMPLANT	☐	☐
STOMACH ULCER	☐	☐
KIDNEY TROUBLE	☐	☐
TUBERCULOSIS	☐	☐
PERSISTENT COUGH	☐	☐
COUGH THAT PRODUCES BLOOD	☐	☐
CHEMOTHERAPY (CANCE, LEUKEMIA)	☐	☐
SEXUALLY TRANSMITTED DISEASE	☐	☐
EPILEPSY OR SEIZURES	☐	☐
ANEMIA	☐	☐
GLAUCOMA	☐	☐
NERVOUSNESS	☐	☐
TONSILITIS	☐	☐
TUMORS	☐	☐
MENTAL HEALTH CARE	☐	☐
BACK PROBLEMS	☐	☐
CHEMICAL DEPENDENCY	☐	☐
MITRAL VALVE PROLAPSE	☐	☐
CORTISONE TREATMENT1	☐	☐
COLD SORES/FEVER BLISTERS	☐	☐
HYPOGLYCEMIA	☐	☐
EATING DISORDERS	☐	☐

HEALTH HISTORY

PATIENT DENTAL HISTORY

PATIENT'S NAME _____ DATE OF BIRTH _____

REASON FOR THIS VISIT _____

WHEN WAS YOUR LAST DENTAL VISIT _____ WHAT WAS DONE _____

HOW OFTEN DID YOU VISIT THE DENTIST _____

PREVIOUS DENTIST (NAME AND LOCATION) _____

HAVE YOU HAD A COMPLETE SERIES OF DENTAL FILMS (X-RAYS) TAKEN? WHEN? WHERE? _____

HOW OFTEN DO YOU BRUSH YOUR TEETH _____ HOW OFTEN DO YOU FLOSS YOUR TEETH _____

IS YOUR DRINKING WATER FLUORIDATED _____

	YES	NO
DO YOUR GUMS BLEED WHILE BRUSHING OR FLOSSING?	☐	☐
ARE YOUR TEETH SENSITIVE TO HOT OR COLD LIQUIDS/FOODS?	☐	☐
ARE YOUR TEETH SENSITIVE TO SWEET OR SOUR LIQUIDS/FOODS?	☐	☐
DO YOU HAVE PAIN IN ANY AREA OF YOUR MOUTH?	☐	☐
DO YOU HAVE ANY SORES OR LUMPS IN OR NEAR YOUR MOUTH?	☐	☐
HAVE YOU HAD HEAD, NECK OR JAW INJURIES?	☐	☐
HAVE YOU EXPERIENCED THE FOLLOWING PROBLEMS WITH YOUR JAW?		
CLICKING	☐	☐
PAIN (JOINT, EAR, SIDE OF FACE	☐	☐
DIFFICULTY IN OPENING OR CLOSING	☐	☐
DIFFICULTY IN CHEWING	☐	☐

	YES	NO
DO YOU HAVE FREQUENT HEADACHES?	☐	☐
DO YOU CLENCH OR GRIND YOUR TEETH?	☐	☐
DO YOU BITE YOUR LIPS OR CHEEKS FREQUENTLY?	☐	☐
HAVE YOU NOTICED YOUR TEETH BECOMING LOOSE?	☐	☐
DOES FOOD TEND TO BECOME CAUGHT BETWEEN YOUR TEETH?	☐	☐
HAVE YOU HAD PERIODONTAL TREATMENT (GUMS)?	☐	☐
EVER WORN A BITE PLATE OR NIGHT GUARD?	☐	☐
HAVE YOU HAD DIFFICULT EXTRACTIONS IN THE PAST?	☐	☐
HAVE YOU HAD PROLONGED BLEEDING FOLLOWING EXTRACTIONS?	☐	☐
DO YOU WEAR DENTURES OR PARTIALS	☐	☐
IF YES, DATE OF PLACEMENT _____		
HAVE YOU RECEIVED ORAL HYGIENE INSTRUCTIONS REGARDING THE CARE OF YOUR TEETH AND GUMS	☐	☐

IF YOU COULD CHANGE ANYTHING ABOUT YOUR SMILE, WHAT WOULD YOU CHANGE? _____

AUTHORIZATION AND RELEASE

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION AND THAT ALL ABOVE QUESTIONS HAVE BEEN ACCURATELY ANSWERED TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. 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 COURSE OF SUCH DENTAL CARE TO THIRD PARTY PAYORS AND/OR HEALTH PRACTITIONERS. IF AUTHORIZED I REQUEST MY INSURANCE COMPANY TO PAY MY DENTIST OR DENTAL GROUP DIRECTLY. I UNDERSTAND THAT MY DENTAL INSURANCE CARRIER MAY PAY LESS THAN THE ACTUAL BILL FOR SERIVCES. I AGREE THAT I AM RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED ON BEHALF OF MYSELF OR MY DEPENDENTS.

X _____ DATE _____

SIGNATURE OF PATIENT /GUARDIAN IF MINOR

DOCTOR'S COMMENTS _____

SIGNATURE _____ DATE _____

HEALTH HISTORY

DENTAL WELLBEING
7720 W. Sahara Ave. #114 Las Vegas, NV 89117 *(702) 648-1200 *Fax (702) 360-0193

Patient Name:_____ Date of Birth:_____

Treatment Authorization and Financial Agreement

As I have requested the care of Dental Wellbeing and I hereby authorize them to release any information to my insurance company necessary to facilitate treatment or secure payment of service rendered. Information may include but not limited to the following: diagnosis, treatment plan, xrays, laboratory, consultaion and follow up documentation. I also authorize and request that my insurance payer or other third party administrator pay service directly to Dental Wellbeing.

I understand that I am financially responsible for all services rendered and that the eligibility agreement is between my insurance company and me. As a courtesy to me, Dental Wellbeing will make every effort to secure payment from my insurance company before turning to me for payment. I understand that I am responsible for all cost shares (copayments) and deductibles at the time of service. I can pay cash, check, credit card; however should my check be reurned by the bank for insufficient funds there will be a $25.00 return item fee added to my account.

I understand that Dental Wellbeing is entitled to contact me directly for payment should my insurance company deny coverage or not pay for services rendered. Unpaid balances will be due monthly and i will make arrangements to pay the balance, otherwise the unpaid balance will be turned over to a collection agency. Should the use of a collection agency be needed, I will also be responsible for the fee charged be the collection agency to collect any unpaid balance. I have been informed that the collection agency fee can be up to 35% of the unpaid balance amount, therefore increasing the balance originally owed. I also agree to keep the office up to date with my personal information relating to changes in insurance coverage, mailing address, medical history, medications and any other changes that may affect the treatment and care rendered to me. I understand that I am financially responsible for a **$40.00 NO SHOW FEE** if not given 24 hour notice.

_____ _____
Patient/Guradian Signature Date

Health Information Policy

I have received a copy of Dental Wellbeing Information Pratices detailing how my information may be used and disclosed as permitted under federal and state law.
I understand that Dental Wellbeing may leave a message on my answering machine or with a third party regarding limited dental information, pending appointments, or other dental care related communications

_____ _____
Patient/Guradian Signature Date

NOTICE OF PRIVACY PRACTICE ACKNOWLEDGEMENT

Dental Wellbeing
7720 W Sahara #114
Las Vegas, Nv 89117

I understand that, under the Health Insurance Portability & Accountability Act of 1996, ("HIPPA"), 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 assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practice containing a complete description of 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 of health care operations. I also understand you are not required to agree to my requested restrictions, but if you do not 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 acknowledgment on this *Notice of Privacy Practices Acknowledgement* but was unable to do so as documented below:

Date_____ Initials _____ Reason _____

REGISTRATION