NLV DENTAL GROUP

Thank you for trusting us with your dental care. We promise to do our best to provide you with the finest care available. If you have any questions please do not hesitate to inform us and most importantly, welcome!

SS #: _____

Date: _____

PATIENT INFOMATION

Name: _____ Birthdate: _____ Home Phone: (____)_____

Address: _____ Apt. #: _____ City: _____ State: _____ Zip: _____

Sex: ☐ Male ☐ Female Status: ☐ Married ☐ Separated ☐ Widowed ☐ Divorced ☐ Single ☐ Partnered for _____ years ☐ Minor

E-mail: _____ Cell Phone: (_____)_____ Other: (_____)_____

Employer/School: _____ Employer/School Phone: (_____)_____

Employer/School Address: _____ City: _____ State: _____ Zip:_____

Whom may we thank for referring you? _____

Who is your emergency contact? _____ Relationship: _____ Phone: (____)_____

RESPONSIBLE PARTY

If you are the patient and are over the age of 18, please mark "Self" and skip the rest of this section. ☐ Self

Name of Person Responsible for account: _____ Relationship: _____

Driver's License #: _____ Birthdate: _____

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

Are you currently a patient in our office? ☐ Yes ☐ No

PRIMARY INSURANCE INFORMATION

If patient is currently enrolled in the Medicaid dental program, please mark "Medicaid" and skip the rest of this section. ☐ Medicaid

Name of Insured:_____ Relationship to Patient:_____

Birthdate:_____ Social Security # : _____

Employer:_____

Insurance Company: _____ Member ID #: _____

Date of Last Dental Visit? (If not sure, approximate time): _____

DENTAL HISTORY

Medicaid patients over 21, please be aware that you are only covered for extractions, dentures and/or partials. Any other dental treatment is strictly out of pocket. Are you here for any of these reasons?
☐ Yes ☐ No

Reason for today's visit: _____

_____

_____

How often do you floss?_____

How often do you brush?_____

Please check "Yes" or "No" to indicate if you have had any of the following:

Bad Breath	☐Yes	☐No	Jaw Pain/Tenderness	☐Yes	☐No
Bleeding Gums	☐Yes	☐No	Lip/Cheek Biting	☐Yes	☐No
Smoking	☐Yes	☐No	Loose Teeth	☐Yes	☐No
Clicking/ Poppin Jaw	☐Yes	☐No	Broken Fillings	☐Yes	☐No
Dry Mouth	☐Yes	☐No	Braces	☐Yes	☐No
Fingernail Biting	☐Yes	☐No	Pain Around Ear	☐Yes	☐No
Food Collection Between Teeth	☐Yes	☐No	Sensitivity To Cold	☐Yes	☐No
Grinding Teeth	☐Yes	☐No	Sensitivity To Heat	☐Yes	☐No
Gums Swollen or Tender	☐Yes	☐No	Sensitivity To Sweets	☐Yes	☐No
Growths In Mouth/On Gums	☐Yes	☐No	Sensitivity When Biting	☐Yes	☐No

*OVER *

MEDICAL HISTORY

Please check "Yes" or "No" to indicate if you've been diagnosed with any of the following:

HIV/AIDS	☐Yes	☐No
Anemia	☐Yes	☐No
Arthritis/Rheumatism	☐Yes	☐No
Asthma	☐Yes	☐No
Lumbar Problems	☐Yes	☐No
Cancer	☐Yes	☐No
Chemical Dependency	☐Yes	☐No
Chemotherapy	☐Yes	☐No
Circulatory Problems	☐Yes	☐No
Cortisone Treatment	☐Yes	☐No
Cough, Persistent or Bloody	☐Yes	☐No
Diabetes	☐Yes	☐No
Emphysema	☐Yes	☐No
Fainting or Dizziness	☐Yes	☐No
Glaucoma	☐Yes	☐No
Headaches	☐Yes	☐No
Cardiac Problems	☐Yes	☐No
Hepatitis Type ____	☐Yes	☐No
Herpes	☐Yes	☐No
High/Low blood Pressure	☐Yes	☐No
Jaundice	☐Yes	☐No
Renal Conditions	☐Yes	☐No
Liver Conditions	☐Yes	☐No
Jaw Pain	☐Yes	☐No
Psychiatric Care	☐Yes	☐No
Respiratory Problems	☐Yes	☐No
Scarlet Fever	☐Yes	☐No
Stroke	☐Yes	☐No
Swollen Feet or Ankles	☐Yes	☐No
Thyroid Condition	☐Yes	☐No
Tobacco Use	☐Yes	☐No
Tuberculosis	☐Yes	☐No
Ulcers	☐Yes	☐No
Venereal Diseases	☐Yes	☐No

Have you ever been diagnosed with any of the following?:

Artificial Heart Valve	☐Yes	☐No
Abnormal Bleeding after extractions or any other surgery	☐Yes	☐No
Blood Conditions	☐Yes	☐No
Congenital Heart Lesions	☐Yes	☐No
Heart Murmur	☐Yes	☐No
Hernia Repair	☐Yes	☐No
Mitral Valve Prolapse	☐Yes	☐No
Pacemaker	☐Yes	☐No
Rheumatic Fever	☐Yes	☐No

Other:_____

Are you allergic to:

Aspirin	☐Yes	☐No
Barbiturates	☐Yes	☐No
Codeine	☐Yes	☐No
Ibuprofen	☐Yes	☐No
Latex	☐Yes	☐No
Local Anesthesia	☐Yes	☐No
Metal (gold, silver, etc.)	☐Yes	☐No
Penicillin	☐Yes	☐No

Other:_____

Have you ever had any complications following dental treatment? ☐Yes ☐No

If so, explain_____

Any other medical history_____

_____

Women:

Are you pregnant?	☐Yes	☐No
Are you nursing?	☐Yes	☐No
Are you taking birth control?	☐Yes	☐No

Approximate Due Date:_____

Medications currently taking_____

I understand that to the best of my knowledge the information given is complete and correct. I am aware that it is my responsibility to inform my dentist if my health or that of my child changes in the future.

_____ _____

Patient Signature (Parent or legal guardian if patient is a minor) **Date**

Informed Consent of General Dentistry

Procedures Iniciales
I understand that I need the following:
* X-Ray
* Treatment Plan INITIALS_____

Medication
I understand that antibiotics, analgesics and/or other medications can cause allergic reactions causing swelling, pain, vomiting, itching, and/or anaphylactic shock.
INITIALS_____

Changes in Treatment Plan
I understand that during treatment it may be necessary to change or add procedures for any condition encountered during dental treatment. INITIALS_____

Extractions
The alternatives of an extraction have been explained to me And I authorize the dentist to do the selected extraction or others that are necessary. I understand that extractions do not always remove all of the infection and the risks or complications that may arise. I will be given a more detailed form explaining the care and risks during and after an extraction. INITIALS _____

Endodontics
Killing the root canals can eliminate infection, relieve pain, and keep teeth in a better state. Complications during treatment may arise as with any other procedure including necessary extraction. Under these circumstances, following the extraction, the alternatives include bridge or dental implant.
INITIALS _____

Crowns
The use of crowns prevents a tooth fracture, restores a tooth already broken, eliminates a space where food tends to get stuck, hold a false tooth in place as part of a bridge and/or create a solid structure to hold a partial. Possible complications include crown fracture, loosening of the crown in which it would have to be re-cemented, future decay requiring a new crown. INITIALS_____

Bridges
Bridge construction can make your smile more enjoyable (cosmetically), replace missing teeth without a removable prosthesis, improve chewing and have the same general benefits as a crown. The possible complications are the same as those described in the Crown section. The consequences of not doing the job or postponing it, can cause displacement and tipping of teeth, loss of posterior teeth due to displacement, periodontal problems and/or gum disease.
INITIALS_____

Partial
A partial replaces the teeth already extracted or missing to extract depending on my treatment plan. The possible complications are that the partials can cause wear on the teeth Natural and can stress or loosen teeth or create cavities under the metal. INITIALS_____

Dentures
I understand the use of dentures is difficult. The immediate denture (placement of the denture immediately after extractions) can be painful. It may require several major adjustments. I understand that it is my responsibility to return for relines and adjustments as time goes on to have better long-term results. INITIALS_____

Periodontal (tissue and bone)
I understand that I need gum maintenance along with deep cleaning. Consequences of not doing my treatment or prolonging it can result in inflammation and/or gum bleeding, bone loss and as a result, tooth loss.
INITIALS_____

Restorations
I understand that care should be exercised in chewing especially during the first 24 hours to prevent fracture of the filling or my own tooth. I understand that a bigger filling than originally diagnosed may be required due to additional decay. I understand that there may be sensitivity after a restoration like this and that I can make a no-charge adjustment.
INITIALS_____

I understand all the procedures, their care, expectations, and complications. I know the importance of each one of the procedures if I need them and I will be responsible for my oral health or that of the minor patient.

Patient Signature (Parent or legal guardian if patient is a minor) Date

Financial Responsibilities

Name of the Patient: _____ Date _____

The charges set for each individual patient are considered a contract between the patient and the dental office. Although we process the collection benefits from your dental insurance, for the convenience of our patients, the patient is directly (with the exception of a minor) responsible with our office of payment of your account.

There are cases where companies do not pay 100% of the charges. Some of them pay only a certain fixed amount for some procedures, and others only pay a percentage of the charges. It is the patient's responsibility to pay the deductibles, co-payments, or other balance that is not paid by the insurance.

It is our dental office's policy that all charges be paid at the time of service. Payments can be settled in the following ways:

- **Cash**
- **Debit/Credit card (Visa, MasterCard, American Express, etc.)**
- **Health Financing Programs (GreenSky, Care Credit)**

Any account that has a balance payable that spans for more than 90 unliquidated days will be sent to a collection agency.

_____ _____

Patient Signature (Parent or legal guardian) Date

INSURANCE POLICY

Your insurance policy is a contract between you and your insurance company. We are not a party in that contract. We will send out your bill to your insurance company and it is your responsibility to make sure we receive payment in full within a 45-day period regardless if your insurance company pays or not. Please be aware that some or all services rendered might not be covered by your insurance policy and we explain this protocol so that you are aware of your responsibility. In regard to all contracts with insurance companies which we are providers for: All co-payments and deductibles should be paid in full on the date which the dental services are rendered.

APPOINTMENT POLICY

Being a patient, your appointment is very important to us as it is for you and your family. Here at NLV Dental Group we try our best to confirm all appointments one day prior, but it is your responsibility to confirm your own appointment for the corresponding date and time. **There will be a $50.00 fee added to your account for same day cancellations or no call no shows for appointments on a weekday and an $80.00 fee for appointments during the weekend.** Please keep in mind that cancellations must be done with at least 48-hour notice. Additionally, if the patient is more than 15 minutes late for his/her appointment, NLV Dental Group reserves the right to cancel the scheduled appointment and proceed with fees. We appreciate your cooperation.

Sincerely, Corporate.

Signature:_____ Date:_____

Under-Age Patients

What we need from the parent or Legal Guardian responsible for the patient:

1. Identification of the person responsible for the patient.
2. Dental Insurance Card along with information from the person in charge of the insurance for verification.

Please do not leave small children unattended in the lobby. We do not want the other patients to be disturbed.

Due to the consideration of safety, children cannot be left unattended in the waiting room, nor can they accompany their parents in the treatment area. Please take appropriate child care measures before you arrive at our office so that you do not need to reschedule your appointment. Thank you.

For our patients under 18 years of age, a parent or responsible person should remain at the facility during the patient's dental procedure.

I authorize to give any necessary dental or medical information to my insurance company to proceed with the rendering of services provided by this dental office.

I, _____

authorize dental treatment for _____.

I authorize the assignment of myself or the patient to this office if required by my insurance in order to be a new dental office patient at NLV Dental Group.

_____

Patient Signature (parent or legal guardian responsible) Date

Our Clinic's Privacy Policy Notice

We are required to provide you with a copy of our privacy practices notice, which indicates how we can use your health information. By signing the form you agree to that notice. You have the right to refuse the option to sign the form if you wish.

I have read and understood the notice about the privacy practices of the office.

Name of the Patient: _____

Patient Signature :_____
(Parent or legal guardian)

Date: _____

****

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgement of receipt of our notice of privacy from this patient but it could not be obtained due to :

PATIENT REFUSTED TO SIGN FORM

DUE TO AN EMERGENCY SITUATION IT WAS NOT POSSIBLE TO OBTAIN ACKNOWLEDGEMENT

WE WERE UNABLE TO COMMUNICATE WITH THE PATIENT

***OTHER (PLEASE PROVIDE SPECIFIC DETAILS) ***

Information About The HIPAA Act

The law known as "The Health Insurance Portability and Accountability Act (HIPAA) "provides guarantees to protect your privacy. Application of The HIPAA requirements officially started on April 14, 2003. Many of HIPAA's policies have been our practice for years. This form is a "friendly" version. A more detailed text can be found online.

What is it? Specifically, there are rules and restrictions on who can see or be notified of their information from Protected Health. These restrictions do not include the normal exchange of information necessary to provide services in our clinics. HIPAA provides certain rights and protections to you as a patient. We balance these needs with our goal of providing you with care and service. Additional information is available in the Department of Health and Human Services of the United States. www.hhs.gov

NLV Dental Group has adopted the following policies:

1. Patient information is kept confidential, unless it is necessary to provide services or to ensure that all administrative matters related to your care are properly treated. This includes specifically the exchange of information with other providers of medical care, laboratories, health insurance as needed and appropriate for your care. Patient files are stored in a system electronically. The normal course of care means that such registries can be left open in the computer, only temporarily, in areas of the administrative office, examination room, etc.
Those records will not be available to people who are not staff of the office. You agree with the normal procedures used within the office for card handling, records of patients, PHI and other documents or information.

2. It is the policy of NLV Dental Group to remind patients of their appointments by phone call. We can send you other communications to inform you of changes in the policies of NLV Dental Group and new technology that can be valuable or informative.

3. NLV Dental Group uses a number of vendors in conducting business. These vendors may have
Access to PHI but you must agree to abide by the HIPAA confidentiality rules.

4. You understand and accept office inspections and review of documents that may include PHI by government agencies or insurance payers in the normal performance of their duties.

5. You agree to bring your privacy concerns or complaints to the attention of the clinic manager or doctor.

6. Your confidential information will not be used for marketing purposes or advertising products, goods or services.

7. We agree to provide patients with access to their records in accordance with state law.

8. We can change, add, delete or modify any of these provisions to better serve the
Needs of both NLV Dental Group as well as the patient.

9. You have The right to request restrictions on the use of your protected health information and on request for change in certain directives used within the NLV Dental Group regarding your PHI. However, we are not obliged to alter the policies to comply with your application.

10. NLV Dental Group is part of a collaborative agreement that includes several participants in the medical field. Your information from health can be shared by NLV Dental Group with other participants when necessary for health care operations.