**WELCOME TO SPRING MOUNTAIN DENTAL**

 Thank you for trusting us with your dental care.

 We promise to do our best to provide you with the finest care available.

**PATIENT INFORMATION**

 Last Name                                    Middle Initial First

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Birth date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ • Male • Female

Address  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Apt/Unit\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_    State\_\_\_\_\_\_ Zip\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

• Minor     • Single • Married   • Divorced • Widowed      • Separated

**Social Security Number**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Whom May We Thank for Referring You?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PERSONAL PHONE NUMBERS INFORMATION**

Best Phone number to be contacted between 8am – 5pm:   ( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please circle one:         Home Work     Cell Phone Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please provide a Secondary phone number where we can contact you: (             )\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please circle one:           Home Work   Cell Phone Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **RESPONSIBLE PARTY**

Name of Person Responsible\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relation to Patient\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social Security \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birth date\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Currently a Patient in Our Office:      • Yes • No

 **EMERGENCY CONTACT**

Person to Contact in Case of Emergency\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Best number to contact this person  ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **DENTAL HISTORY**

 Main reason for Today’s visit\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Date of last Dental visit/Dental X-ray\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 How often do you floss?  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 How often do you brush?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CIRCLE**  if you have had any of the following:

• Bad breath   • Teeth grinding • Sensitivity to heat

• Bleeding gums • Loose teeth or broken filling • Sensitivity to sweet

• Clicking or popping jaw • gum treatment • Sensitivity when biting

 •Food collection between the teeth • Sensitivity to cold • Sores or growths in your mouth

**Medical History**

**Physician’s Name**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of last visit** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Artificial (prosthetics) heart valve ●Y ●N Previous infective endocarditis ●Y ●N

Damages valves in transplanted heart ●Y ●N Congenital heart disease(CHD) ●Y ●N

Unrepaired, cyanotic CHD ●Y ●N Repaired (completely) in last 6 months ●Y ●N

Repaired CHD with residual defects ●Y ●N

Have you taken any group of drugs collectively referred to a “fen-phen?” These include combination of Ionimin, Adipex, Fastin (brand names of phentermine). Pondimin (fenfluramine) and Redux (dexfenfluramine). ● Y ●N

Have you had any serious illnesses or operations? ●Y ●N If yes, describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had a blood transfusion? ●Y ●N If yes, give approx, dates \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you take any medications? ●Y ●N Which and correlating condition?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you allergic to any medications/anesthetics? ●Y ●N If yes, which?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |
| --- | --- |
| Are you under a physician’s care now? ○Yes ○No Phyiscian’s Name and Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |  |
| Have you ever been hospitalized or had a major operation? ○Yes ○No | If Yes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Have you ever had a serious head or neck injury? ○Yes ○No | If Yes\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Are you taking any medications, pills, or drugs? ○Yes ○No   | If Yes\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Do you take, or have you taken, Phen-Fen or Redux? ○Yes ○No | If Yes\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ○Yes ○No | If Yes\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Are you on a special diet? ○Yes ○No | If Yes\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Do you use tobacco? ○Yes ○No | If Yes\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Do you use controlled substances? ○Yes ○No | If Yes\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Women: Are you…**○Pregnant/Trying to get pregnant? ○Nursing? ○Taking **Are you allergic to any of the following?**

|  |  |  |  |
| --- | --- | --- | --- |
| ○Aspirin | ○Penicillin | ○Codeine  | ○Acrylic |
| ○Metal | ○Latex | ○Sulfa Drugs  | ○Local Aesthetics |
| ○Other |  |  |  |

 | Oral contraceptives○Acrylic○Local Anesthetics |

**Please check yes or no:**

|  |  |
| --- | --- |
| AIDS/HIV positive ○Yes ○No | Cortisone Medicine ○Yes ○No |
| Alzheimer’s disease ○Yes ○No  | Diabetes ○Yes ○No |
| Anaphylaxis ○Yes ○No | Drug Addiction ○Yes ○No |
| Anemia ○Yes ○No | Easily Winded ○Yes ○No |
| Angina ○Yes ○No | Emphysema ○Yes ○No |
| Arthritis/Gout ○Yes ○No | Epilepsy or Seizures ○Yes ○No |
| Artificial Heart valve ○Yes ○No | Excessive Bleeding ○Yes ○No |
| Artificial Joint ○Yes ○No | Excessive Thirst ○Yes ○No |
| Asthma ○Yes ○No | Fainting Spells/Dizziness ○Yes ○No |
| Blood Disease ○Yes ○No | Frequent Cough ○Yes ○No |
| Blood transfusion ○Yes ○No | Frequent Diarrhea ○Yes ○No |
| Breathing problems ○Yes ○No | Frequent Headaches ○Yes ○No |
| Bruise easily ○Yes ○No | Genital Herpes ○Yes ○No |
| Cancer ○Yes ○No | Glaucoma ○Yes ○No |
| Chemotherapy ○Yes ○No | Hay Fever ○Yes ○No |
| Chest pains ○Yes ○No | Heart Attack/Failure ○Yes ○No |
| Cold Sores/Fever Blisters ○Yes ○No | Heart Murmur ○Yes ○No |
| Congenital Heart Disorder ○Yes ○No | Heart Pacemaker ○Yes ○No |
| Convulsions ○Yes ○NoYellow Jaundice ○Yes ○NoRepaired CHD with residual ○Yes ○Nodefect  | Heart Trouble/Disease ○Yes ○NoPrevious infective endocarditis ○Yes ○No |

|  |  |
| --- | --- |
| Hemophilia ○Yes ○No | Radiation Treatments ○Yes ○No |
| Hepatitis A ○Yes ○No | Recent Weight Loss ○Yes ○No |
| Hepatitis B or C ○Yes ○No | Renal Dialysis ○Yes ○No |
| Herpes ○Yes ○No | Rheumatic Fever ○Yes ○No |
| High Blood Pressure ○Yes ○No | Rheumatism ○Yes ○No |
| High cholesterol ○Yes ○No | Scarlet Fever ○Yes ○No |
| Hives or Rash ○Yes ○No | Shingles ○Yes ○No |
| Hypoglycemia ○Yes ○No | Sickle Cell Disease ○Yes ○No |
| Irregular Heartbeat ○Yes ○No | Sinus Trouble ○Yes ○No |
| Kidney Problems ○Yes ○No | Spinal Bifida ○Yes ○No |
| Leukemia ○Yes ○No | Stomach/Intestinal Disease ○Yes ○No |
| Liver Disease ○Yes ○No | Stroke ○Yes ○No |
| Low Blood Pressure ○Yes ○No | Swelling of Limbs ○Yes ○No |
| Lung Disease ○Yes ○No | Thyroid Disease ○Yes ○No |
| Mitral Valve Prolapse ○Yes ○No | Tonsillitis ○Yes ○No |
| Osteoporosis ○Yes ○No | Tuberculosis ○Yes ○No |
| Pain in Jaw Joints ○Yes ○No | Tumors or Growths ○Yes ○No |
| Parathyroid Disease ○Yes ○No | Ulcers ○Yes ○No |
| Psychiatric Care ○Yes ○NoDamaged valves in transplanted ○Yes ○Noheart | Venereal Disease ○Yes ○NoUnrepaired cyanotic CHD ○Yes ○No |

Have you ever had any serious illness not listed above? ○Yes ○No Describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**AUTHORIZATION AND RELEASE**

**I have read and answered the above questions to the best of my knowledge. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I authorize the doctor to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of this signature on all insurance submission.**

***Payment is due in full at time of Treatment unless prior arrangements have been approved.***

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of patient or Signature of guardian if minor Date

**I have reviewed this patient’s information and medical history.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dr’s Signature Date

**SPRING MOUNTAIN DENTAL**

**PATIENT CONSENT/ ACKNOWLEDGEMENT FORM**

By signing below, you consent to the use and disclosure of your protected health information by Patel and Byun A Dental Corporation, our staff, and our business associate for treatment, payment, and healthcare operations. For a more detailed description of uses and disclosures for these purposes, please review our Notice of Information Practices (“Notice”). You have the right to review our notice prior to signing this consent. The terms of this notice may change. If the terms do change, you may obtain a revised notice by simply contacting Patel and Byun A Dental Corporation, at 702-368-3854. Any revision will also be posted in the offices of Patel and Byun A Dental Corporation at 5785 Spring Mountain Rd. Las Vegas, NV. 89146.

You have the rights to request that we restrict our uses and disclosures of your protected health information that we are otherwise permitted to make for treatment, payment, and health care operations, although we are not required to agree to these restrictions. However, if we agree to further restrictions, they are binding to us. Finally, you may refuse to consent to the use of disclosure of your protected health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your protected health information (PHI).

**THIS FORM IS ALSO USED TO OBTAIN ACKNOWLEDGEMENT OF RECEIPT OF OUR NOTICE OF PRIVACY PRACTICES OR TO DOCUMENT OUR GOOD FAITH EFFORT TO OBTAIN THIS ACKNOWLEDGEMENT.**

**I HAVE REVIEWED, UNDERSTAND, AND AGREE TO THE CONSENT OF THIS NOTICE OF PRIVACY.**

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **SPRING MOUNTAIN DENTAL**

**TREATMENT AUTHORIZATION**

Insurance coverage is estimated on what your insurance will cover for a procedure. Your actual indemnity may be more or less than the estimate. You, the patient, are responsible for all amounts not covered by your insurance carrier.

Year-to-date, used benefits and remaining deductible amounts are not affected until procedure is completed; therefore, they are not included in this determination of benefits.

This office will attempt to collect from your Insurance Company for services rendered by our office. Failure from your insurance company to pay the claim within 30 days of the date of service will result in your being billed personally for the entirety of the outstanding balance and payable within 10 days. Failure of this office to receive payment within 10 days will result in more aggressive collection activity.

**I,\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, assume responsibility for all charges not covered by my Insurance Carrier.**

**I have fully read and understand the policy above.**

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SPRING MOUNTAIN DENTAL**

5785 SPRING MOUNTAIN RD.

LAS VEGAS, NV. 89146

**NO SHOWS AND CANCELLATION POLICY**

A scheduled appointment is a commitment of time between the Doctor and Patient. We have reserved that time **JUST FOR YOU**. When appointments are missed or cancelled, that time is lost. We ask that when you schedule your treatment, you make every effort to keep that commitment.

If you find you are unable to keep your scheduled appointment, a **48-hour** notice will allow us to schedule another patient in need of treatment. It is our policy that, with less than **48-hour notice** on a change of commitment, a **$50.00 charge** will be applied to your account.

Patients showing three or more missed appointments on record will be required to prepay for all future appointments in full.

I have fully read and understand the policy above.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness Signature Date

 **Spring Mountain Dental**

5785 Spring Mountain Rd.

 Las Vegas, NY 89146

 (702) 368-3854

The use of Chlorhexidine Gluconate is incorporated into adult cleaning procedures performed in this office. It provides anti-microbial activity by flushing the gingival tissue and gingival sulcus

with this product during cleaning. Health of the soft tissue of the mouth is improved after

cleaning. This therapy helps reduce the redness and swelling of gums, helps control bleeding of

the gums, and promotes healing. Questions regarding this benefit should be directed to your

Hygienist at the time of the appointment. This is a non-covered benefit by insurance companies.

**The fee for this service is as follows:**

|  |  |  |  |
| --- | --- | --- | --- |
| **PROCEDURE** | **ADA CODE** | **IRRIGATION FEE** | **FLUORIDE RINSE FEE** |
| Routine Cleanings | 1110 | $25.00 | $15.00 |
| Gross Debridement | 4355 | $25.00 | $15.00 |
| Perio Maintenance | 4910 | $25.00 | $15.00 |
| Root Planing/Quad | 4341 | $25.00 | $15.00 |

The patient will be responsible for the above fees.

Effective January 1, 2004, this office has limited its use to silver colored filling materials to

specific treatment dictated uses. All filling materials in anterior and posterior teeth will be

accomplished with more modem, state of the art, tooth colored, bonded materials. Most insurance companies provide benefit only for silver colored filling materials. Fees for the placement of these more difficult to place restorations above that benefited by your insurance company are the responsibility of the patient.

**EXAMPLE:**

Dentist fee for white filling - insurance coverage for silver filling = patient co-pay.

I have fully read and understand the policies described above and agree to pay any fees not

covered by my insurance company.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness Signature