



**DENTAL PATIENT INFORMATION**

Today's Date: \_\_\_\_\_

First Name: \_\_\_\_\_ Middle Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Name that you prefer to be called: \_\_\_\_\_

Sex:  M  F Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Email address: \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone number: (h) \_\_\_\_\_ (c) \_\_\_\_\_ (w) \_\_\_\_\_

Preferred method of communication:  Phone call  Text message  Email

Marital status:  M  S  W  D

Are you presently employed?  Full time  Part time  Unemployed  Disabled  Retired

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

What is the reason for seeing us today? \_\_\_\_\_

Did you sustain an injury at work?  Yes  No

Are your injuries accident related?  Yes  No

If yes, please explain: \_\_\_\_\_

Who may we thank for referring you? \_\_\_\_\_

What can we do to ensure your experience with us is a pleasant one? \_\_\_\_\_

What was the reason you stopped seeing your previous dentist? \_\_\_\_\_

**DOCTOR HISTORY**

Primary Care or Referring Physician (Name & Phone): \_\_\_\_\_

Previous Dentist (Name & Phone): \_\_\_\_\_

**EMERGENCY CONTACTS**



Emergency Contact (Name & Phone): \_\_\_\_\_

**Primary Dental Insurance**

Insurance Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ Subscriber Employer: \_\_\_\_\_

Subscriber Social Security #: \_\_\_\_\_ Subscriber Date of Birth: \_\_\_\_\_

Group / Policy Number: \_\_\_\_\_ Is this an employer or union policy? \_\_\_\_\_

**Secondary Dental Insurance**

Insurance Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ Subscriber Employer: \_\_\_\_\_

Subscriber Social Security #: \_\_\_\_\_ Subscriber Date of Birth: \_\_\_\_\_

Group / Policy Number: \_\_\_\_\_ Is this an employer or union policy? \_\_\_\_\_

**Primary Medical Insurance**

Insurance Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ Subscriber Employer: \_\_\_\_\_

Subscriber Social Security #: \_\_\_\_\_ Subscriber Date of Birth: \_\_\_\_\_

Group / Policy Number: \_\_\_\_\_ Is this an employer or union policy? \_\_\_\_\_

Do you have secondary medical insurance? \_\_\_\_\_

\*Please present your insurance card to be photocopied for our record

### MEDICAL HISTORY

Patient's Name: \_\_\_\_\_

Today's Date: \_\_\_\_\_

Date of Last Physical: \_\_\_\_\_

Weight: \_\_\_\_\_

Height: \_\_\_\_\_

**Please check if you have ever had any of the following:**

- |  |  |  |
|--|--|--|
| <ul style="list-style-type: none"> <li><input type="checkbox"/> Allergies (seasonal)</li> <li><input type="checkbox"/> Allergies to latex</li> <li><input type="checkbox"/> Allergies to medications</li> <li><input type="checkbox"/> Acid Reflux/ GERD</li> <li><input type="checkbox"/> Anemia</li> <li><input type="checkbox"/> Arthritis</li> <li><input type="checkbox"/> Asthma</li> <li><input type="checkbox"/> Angina / Chest pain</li> <li><input type="checkbox"/> Anxiety</li> <li><input type="checkbox"/> Blood disease</li> <li><input type="checkbox"/> Breast Implants</li> <li><input type="checkbox"/> Breathing problems</li> <li><input type="checkbox"/> Bleeding disorder</li> <li><input type="checkbox"/> Chronic bronchitis</li> <li><input type="checkbox"/> Chronic fatigue</li> <li><input type="checkbox"/> Cancer or tumors</li> <li><input type="checkbox"/> Circulation problems</li> <li><input type="checkbox"/> Congenital heart condition</li> <li><input type="checkbox"/> Diabetes</li> <li><input type="checkbox"/> Drug / Alcohol abuse</li> <li><input type="checkbox"/> Depression</li> <li><input type="checkbox"/> Dizziness</li> <li><input type="checkbox"/> Earaches</li> <li><input type="checkbox"/> Emphysema</li> <li><input type="checkbox"/> Epilepsy / seizures</li> </ul> | <ul style="list-style-type: none"> <li><input type="checkbox"/> Fainting / dizzy spells</li> <li><input type="checkbox"/> Glaucoma</li> <li><input type="checkbox"/> Gall bladder problems</li> <li><input type="checkbox"/> Herpes</li> <li><input type="checkbox"/> Heart disease</li> <li><input type="checkbox"/> Heart Valve replacement</li> <li><input type="checkbox"/> Head / neck trauma</li> <li><input type="checkbox"/> Heart attack</li> <li><input type="checkbox"/> Healing problems</li> <li><input type="checkbox"/> Headaches</li> <li><input type="checkbox"/> Heart murmur</li> <li><input type="checkbox"/> Hepatitis</li> <li><input type="checkbox"/> High blood pressure</li> <li><input type="checkbox"/> High cholesterol</li> <li><input type="checkbox"/> HIV / AIDS</li> <li><input type="checkbox"/> Immune system disorder</li> <li><input type="checkbox"/> Infective endocarditis</li> <li><input type="checkbox"/> Jaundice</li> <li><input type="checkbox"/> Joint disease</li> <li><input type="checkbox"/> Joint replacement</li> <li><input type="checkbox"/> Kidney disease</li> <li><input type="checkbox"/> Liver disease</li> <li><input type="checkbox"/> Lupus</li> <li><input type="checkbox"/> Mitral valve prolapse</li> <li><input type="checkbox"/> Neurological problems</li> </ul> | <ul style="list-style-type: none"> <li><input type="checkbox"/> Neurological disorder</li> <li><input type="checkbox"/> Osteoarthritis</li> <li><input type="checkbox"/> Osteoporosis</li> <li><input type="checkbox"/> Persistent cough</li> <li><input type="checkbox"/> Panic attacks</li> <li><input type="checkbox"/> Prosthetic joint</li> <li><input type="checkbox"/> Prosthetic heart valve</li> <li><input type="checkbox"/> Psychiatric care</li> <li><input type="checkbox"/> Psychological disorders</li> <li><input type="checkbox"/> Pacemaker</li> <li><input type="checkbox"/> Radiation therapy</li> <li><input type="checkbox"/> Ringing in ears (Tinnitus)</li> <li><input type="checkbox"/> Rheumatic fever</li> <li><input type="checkbox"/> Rheumatoid arthritis</li> <li><input type="checkbox"/> Shortness of breath</li> <li><input type="checkbox"/> Sinus problems</li> <li><input type="checkbox"/> STD</li> <li><input type="checkbox"/> Sleep apnea</li> <li><input type="checkbox"/> Stomach problems</li> <li><input type="checkbox"/> Stroke</li> <li><input type="checkbox"/> Tuberculosis</li> <li><input type="checkbox"/> Thyroid disorder</li> <li><input type="checkbox"/> Ulcers</li> <li><input type="checkbox"/> Other _____</li> </ul> |
|--|--|--|

Eating disorder

Nervous disorders

Do you have any allergies to?




I certify that the above is true to the best of my knowledge. I understand that if there are any changes to my health or medications, I will advise my dentist before beginning any treatment.

Patient Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Patient Signature: \_\_\_\_\_

### DENTAL HISTORY

Patient's Name: \_\_\_\_\_ Date: \_\_\_\_\_ Date of last dental exam: \_\_\_\_\_  
 Date of last cleaning: \_\_\_\_\_ How often do you brush? \_\_\_\_\_ How often do you floss? \_\_\_\_\_

Please check all that apply to you:

- Bleeding gums       Tooth removal       Food gets stuck       Accident in past       Pain when chewing
- Tooth decay    Braces                       Loose teeth               Gum surgery    Jaw surgery
- Broken teeth    Sensitive teeth       Toothache               Bad breath               Hot / cold sensitive
- Wear of teeth       Crowding of teeth       Dry mouth               Other: \_\_\_\_\_

Are you happy with the way your teeth look?     YES     NO If not, why? \_\_\_\_\_

Are you dissatisfied with any of the following?

- Shape of teeth       Crowding               Silver fillings               Color                       Length
- Spacing               Old fillings               Misalignment               "Gummy" smile       Old crowns
- Bad bite               Other

Do you have any sores / spots in mouth that haven't healed for more than 2 weeks?    Yes       No

Please check all that apply to you:

- TMJ problems               Jaw clicking                       Pain in jaw                       Grinding teeth
- Pain in facial area       Numbness in fingers    Tingling in fingers               Dizziness (vertigo)
- Ringing in ears               Numbness in face               Neck or back pain               Jaw clenching
- Tightness in face               Wear a night guard               History of jaw lock               Difficulty chewing



- Difficulty opening mouth
- Pain behind eyes
- Trigeminal neuralgia
- Bells Palsy

Headache history: please check all that apply to you

Location of pain:       Front of head / forehead       Side of head       Back of head

Intensity of pain:      0 (no pain) 1 2 3 4 5 6 7 8 9 10(extreme pain)

Do you suffer from morning headaches?       Yes       No       Sometimes

Do headaches wake you up from sleep?  Yes       No       Sometimes

Do you have nausea with headaches?  Yes       No       Sometimes

Frequency of headaches:       Constant       Once/day       Once every few days       Once/week

Sleep Apnea Assessment: please check all that apply to you

Have you ever been diagnosed with Sleep Apnea?       Yes       No      If yes, when? \_\_\_\_\_

Diagnosing physician: \_\_\_\_\_ Name of sleep center? \_\_\_\_\_

Please check all that apply to you:

- Snoring
- Gastro-esophageal reflux
- Insomnia
- Gasping for air during sleep
- Feel tired in morning
- Poor concentration
- Poor memory
- Difficulty breathing through nose
- Fatigue
- Trouble sleeping
- Nervousness
- Excessive daytime sleepiness
- Irritability
- Anxiety / depression
- Morning stiffness

Have you ever used a CPAP device and could not tolerate it?  Yes       No

If you were not able to tolerate the CPAP, why? \_\_\_\_\_

### Office Financial Policies

We, the staff of Discovery Dental thank you for choosing us as your dental/health provider we are committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. If at any time you have any questions or concerns regarding our fees, policies or responsibilities please feel free to contact our office manager at 702.889.5000

#### **INSURANCE**

Discovery Dental will gladly submit dental claims on your behalf. However, filing your dental claim is not a guarantee of payment for services rendered. We can never guarantee coverage as quoted in our office, estimates and insurance payments are not guaranteed until the claims are processed. The patient portion of dental service(s) is estimated and due at the time of service. This amount may be subject to adjustment when the dental service(s) claim(s) are adjudicated by the insurance company. In addition, certain insurance companies have annual limitation for dental services that can be reimbursed within each plan year. If you or your family exceed these annual limitations in any plan year, you will be responsible for the full amount of dental services that exceed the plan's limitations. The patient is responsible for monitoring the amount of his/her remaining benefits for any annual benefit period. The patient may not rely upon any information provided by Discovery Dental staff regarding his/her remaining benefit in any such benefit period. The claims we submit to insurance companies indicate that you have assigned those benefits to Discovery Dental. However, if you are paid by the insurance company instead of Discovery Dental, you then become responsible for the total account balance and payment would be expected immediately. If you or your family has more than one dental insurance program, we will assist you in obtaining the maximum benefits available. Any charges not paid by your insurance becomes patient's responsibility. Be advised, even preauthorization of services does not guarantee payment from your insurance carrier. You will receive an explanation of benefits (EOB) from your insurance company within 30 to 60 days after the claim of services has been processed. If you have concerns about any items on your EOB, please call our office and we will gladly answer any questions that you may have.



**TREATMENT PLANS**

We will present patients with a TREATMENT PLAN ESTIMATE so that they can understand the estimated costs of recommended treatment prior to its start. The TREATMENT PLAN ESTIMATE is a good-faith attempt to predict the cost of your treatment based on the facts known to Discovery Dental when the estimate is furnished. As treatment progresses, the dentist may determine in consultation that a different approach or additional treatment may be necessary. When this occurs, be advised that patient financial responsibility may change.

**PAYMENTS**

We make payments as convenient as possible by accepting (cash, money order, all major credit cards, personal checks and outside financing.) Payment of services will always be due at the time of service.

**DELINQUENT PAYMENTS**

For any unpaid balances by insurances, the patient will need to contact our office within 30 days to make full payment or set up a payment arrangement Interest will incur if a balance remains unpaid after 60 days. In addition, all payments returned due to non-sufficient funds will be subject to a NSF fee of \$50.00 plus any bank related charges. I also understand that I will bear the entire cost of collection, court costs and attorney fees on my account should this be required to collect outstanding balances at the sole discretion of the dental office.

**MISSED APPOINTMENTS**

We require notice of cancellations 48 hours in advance, our policy is to charge for missed appointments at the rate of \$35.00 per each 30 minutes of missed appointment time. Please help us service you better by keeping scheduled appointments.

Patients Name \_\_\_\_\_ Today's Date: \_\_\_\_\_

Patient or Legal Guardian Signature \_\_\_\_\_

**Privacy Practice Consent Form**

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read the Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain. You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Compliance Officer: Tracey McDonald  
Telephone: 702.889.5000 fax 702.889.6131  
Address: 7581 W. Lakemead Blvd., Ste 160, Las Vegas, NV 89128

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation.

**Please list the full names of any individuals (family, friends, caretakers, etc.) that you would like to have access to your records. The persons listed below will also be able to call our office and discuss your treatment.**



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**Please list Email address** where we can send records: \_\_\_\_\_

I, \_\_\_\_\_ have had full opportunity to read and consider the contents of this Consent form and the Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations.

This authorization is valid from the date of my signature below and will remain in effect until terminated by me in writing.

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

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**If this Consent is signed by a personal representative (parent/guardian) on behalf of the patient complete the following:**

Personal Representative's Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_