PATIENT INFORMATION

Date:_____

PATIENT NAME

Last: _____ First:_____ MI:_____

DATE OF BIRTH: _____ GENDER: M F

ADDRESS:_____

CITY:_____ **STATE**:_____ **ZIP CODE**:_____

CONTACT DETAILS:

PHONE:_____ EMAIL:_____

OTHER DETAILS:

MARITAL STATUS: Married Single Widowed Seperated

PATIENT SSN:_____

REFERRAL INFO:

How did you hear about our office?_____

IF MINOR PLEASE PROVIDE THE FOLLOWING INFORMATION

PARENT/GUARDIAN 1 INFO:

NAME:_____ DATE OF BIRTH:_____

SSN:_____ PHONE:_____

ADDRESS:_____

PARENT/GUARDIAN 2 INFO:

NAME:_____ DATE OF BIRTH:_____

SSN:_____ PHONE:_____

ADDRESS:_____

OTHER INFO:

STUDENT SCHOOL:_____

EMERGENCY INFORMATION

*IN CASE OF EMERGENCY, PLEASE PROVIDE INFORMATION FOR THE NEAREST RELATIVE OR DESIGNATED CONTACT PERSON.

NAME:_____ RELATIONSHIP:_____

PHONE:_____

PRIMARY PHYSICIAN INFORMATION

PROVIDER:_____PHONE:_____

FACILITY NAME:_____

PHARMACY INFORMATION

NAME:_____ PHONE:_____

ADDRESS:_____

HEALTH QUESTIONNAIRE ACKNOWLEDGEMENT AND CONSENT TO PROCEED:
I CERTIFY THAT THE ANSWERS TOTHE HEALTH QUESTIONS ARE ACCURATE AND CORRECT TO THE BEST OF MY KNOWLEDGE. SINCE A CHANGE OF MEDICAL CONDITION OR MEDICATIONS CAN AFFECT DENTAL TREATMENT, I UNDERSTAND THE IMPORTANCE OF AND AGREE TO NOTIFY THE DENTIST OF ANY CHANGES AT ANY SUBSEQUENT APPOINTMENT. I UNDERSTAND THAT THE ADMINISTRATION OF LOCAL ANESTHETIC MAY CAUSE AN UNTOWARD REACTION OR SIDE EFFECTS, WHICH MAY INCLUDE, BUT ARE NOT LIMITED TO BRUISING, HEMATOMA, CARDIAC STIMULATION, TEMPORARY OR RARELY, PERMANENT NUMBNESS, AND MUSCLE SORENESS. I UNDERSTAND THAT AS A RESULT OF DENTAL TREATMENT, INCLUDING PREVENTATIVE PROCEDURES SUCH AS CLEANING AND BASIC DENTISTRY, AS WELL AS FILLINGS OF ALL TYPES, TEETH MAY REMAIN SENSITIVE OR EVEN POSSIBLY QUITE PAINFUL BOTH DURING AND AFTER COMPLETION OF TREATMENT. GUMS AND SURROUNDING TISSUES MAY ALSO BE SENSITIVE OR PAINFUL DURING AND OR AFTER TREATMENT.

CONSENT FOR RECORDS AND TREATMENT:
I GRANT AUTHORITY TO THE DOCTORS AT VALUE DENTAL OF RENO TO TAKE ALL NECESSARY PHOTOS AND RADIOGRAPHS RELEVANT TO MY DENTAL CONDITION. I ALSO AUTHORIZE THE DOCTORS AT VALUE DENTAL OF RENO TO ADMINISTER ANY TREATMENT OR TO ADMINISTER ANESTHETICS, ANALGESICS, SEDATIVES AND NITROUS OXIDE SEDATION, AND TO PERFORM SUCH OPERATIONS AS MAY BE DEEMED NECESSARY OR ADVISABLE IN MY DIAGNOSIS AND TREATMENT. I HAVE READ THE ABOVE TERMS AND CONDITIONS AND CONSENT FOR TREATMENT AND FULLY AGREE TO THEIR CONTENT. I DO VOLUNTARILY ASSUME ANY AND ALL POSSIBLE RISKS, INCLUDING THE RISK OF SUBSTANTIAL AND SERIOUS HARM, IF ANY, WHICH MAY BE ASSOCIATED WITH GENERAL PREVENTATIVE AND OPERATIVE TREATMENT PROCEDURES IN HOPES OF OBTAINING THE POTENTIAL DESIRED RESULTS, WHICH MAY OR MAY NOT BE ACHIEVED, FOR MY BENEFIT.

SIGNATURE OF PATIENT:_____

PRINT NAME:_____ **DATE:** _____

INSURANCE INFORMATION

Our office policy requires **ALL CO-PAYS DUE AT TIME OF SERVICE**. We appreciate your understanding that we bill your insurance as a courtesy, & fees are always **ESTIMATES** based on the information your insurance provides us with.

We recommend you call your insurance along with the estimate we provide to project your most accurate out-of pocket cost.

POLICY HOLDER NAME:

FIRST:_____ LAST:_____ MI:_____

DATE OF BIRTH:_____

HOME ADDRESS:

STREET: _____

CITY:_____ STATE:_____ ZIP CODE:_____

INSURANCE DETAILS:

POLICY HOLDER SSN # / MEMBER ID #:_____

RELATIONSHIP TO PATIENT: _____

EMPLOYER: _____

INSURANCE COMPANY NAME: _____

GROUP # (IF APPLICABLE):_____

PHONE NUMBER OF INSURANCE COMPANY: _____

SIGNATURE: _____ **DATE:**_____

OFFICE POLICY

General

Thank you for choosing our practice as your dental care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we require you to read, and sign prior to treatment. All patients must complete our Information and Insurance form before seeing the doctor. **FULL PAYMENT IS DUE AT TIME OF SERVICE**.

WE ACCEPT CASH, CHECKS, VISA, MASTERCARD, AMERICAN EXPRESS, DISCOVER, and CARECREDIT.

Regarding Insurance

Fees are estimates only, are valid for 60 days from the date shown above and are subject to revision. Treatment could be altered if your dental needs change. The patient will be notified of any change(s) in treatment.

Regarding Insurance Plans where we are a participating provider

All **ESTIMATED** portion and deductibles are due prior to treatment. In the event that YOUR insurance coverage changes to a plan where we are non-participating providers,all costs not covered by your insurance will be your responsibility and are due at time of service**.**

Usual andCustomary Rates

Our practice is committed in providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Adult Patients

Adult patients are responsible for full payment of the determined patient portion at time of service.

MinorPatients

The adult accompanying a minor (or guardians of the minor) are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-approved or payment at time of service has been verified.

Consent

I understand and agree to this Financial Policy.

SIGNATURE: _____ DATE: _____

INSURANCE POLICY

Dental insurance:

Understanding your insurance coverage can be quite a challenge. Our goal is to assist you in maximizing your benefits. We care for patients from many different employers. Each company pays an insurance premium for specific coverage which fits the employer's budget. Each plan is different in its covered services. We encourage you to become familiar with your policy exclusions, deductibles and required co-payments.

Our courtesy service to you includes:

1. Making a good faith estimate of your insurance coverage and deductibles and co-payments to be paid by you for the proposed treatment.
2. Filing your insurance electronically (when available) within 24 hours of service requesting payment be sent directly to Value Dental of Reno.
3. Following all American Dental Association guidelines for coding procedures and filing insurance.

Our expectations of you as the owner of the policy:

1. You are responsible for payment of fees not covered by your insurance.
2. Please understand that the insurance policy belongs to you and we have no leverage to obtain payment from your insurance carrier. The insurance contract is between yourself, the carrier and sometimes your employer.
3. Realize that dental insurance policies restrict payment for some services. They also use restricted fee schedules and exclude some procedures based on prior conditions or length of time on the plan. All restrictions are based on the premium paid for the insurance, not our fees or recommended treatment.
4. You will need to take responsibility for any fees your insurance has not covered after 60 days. At this time, you will be contacted to pay the balance on the account. This balance will be subject to a 1.5%monthly finance charge for the outstanding balance if not paid in full. Any expenses incurred in collecting a past due account will be added to the balance.

Insurance Policy Acknowledgement

By signing this form all policies are understood and agreed to. Insurance Authorization Statement I _____ hereby authorize payment directly to Value Dental of Reno for the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs and dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the medical history is correct to the best of my knowledge.

SIGNATURE: _____ DATE:_____

Patient Appointment Agreement

We make every effort to value your time and schedule your appointment time just for you. We truly appreciate your courtesy in giving us 48 hours' notice if you have a conflict with your appointment and need to schedule a different day or time. We are committed to your oral health care and keeping your scheduled appointments allows us to be partners in your dental care.

- I acknowledge my appointment is a reservation.
- I acknowledge I am required to provide 48 hours' notice to make changes to my appointment.
- I acknowledge that if I am more than 15 minutes late, Value Dental of Reno reserves the right to reschedule my appointment.
- I acknowledge after two missed appointments within 13 months, in which I did not provide 48 hours' notice, I will be required to place a $100 deposit for restorative work or a $50 deposit for hygiene to reserve my appointment. The deposit will be held by Value Dental of Reno if the appointment is missed or canceled within 48 hours.
- If there is a third missed appointment within 13 months, I will need to prepay for the next appointment in full for Value Dental of Reno to reserve the day and time for you. That prepayment will be held by Value Dental of Reno if the appointment is missed or canceled within 48 hours.

SIGNATURE: _____ DATE:_____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASEREVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this notice about our privacy practices our legal duties and your rights concerning your health information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect / / and will remain in effect until we replace it. We reserve the right to change our privacy practices and the terms of this notice at any time provided such changes are permitted by applicable law. We reserve the right to make changes in our privacy practices and the new terms of our notice effective for all health information that we maintain including health information we created or received before we made the changes. Before we make a significant change in our privacy practices we will change this notice and make the new notice available upon request. You may request a copy of our notice at any time. For more information about our practices or for additional copies of this notice please contact us using the information listed at the end of this notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment payment and healthcare operations. For example:

TREATMENT: We may use or disclose your health information to a physician or other health care provider providing treatment to you.

PAYMENTS: We may use and disclose your health information to obtain payment for services we provide to you.

HEALTHCARE OPERATIONS: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities. Reviewing the competence or qualifications of health care professionals,evaluating practitioners and provider performance conducting training programs accreditation,certification, licensing or credentialing activities.

YOUR AUTHORIZATION: In addition to our use of your health information for treatment payment or health care operations you may give us written authorization to use your health information or to disclose it to anyone for any purpose if you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while in effect. Unless you give us a written authorization we cannot use or disclose your health information for any reason except those described in this notice.

TO YOUR FAMILY AND FRIENDS: We must disclose your health information to you as described in this patient rights section of this notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your health care or with payment for your healthcare, but only if you agree that we may do so.

PERSONS INVOLVED IN CARE: We may use or disclose health information to notify or assist in the notification of including identifying or locating a family member your personal representative or another person responsible for your care of your location, your general condition or death. If you are present then prior to use or disclosure of your health information we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practices to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x- rays or other similar forms of health information.

MARKETING HEALTH-RELATED SERVICES: We will not use your health information for marketing communications without your written authorization.

REQUIRED BY LAW: We may use or disclose your health information when we are required to do so by law.

ABUSE OR NEGLECT: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

** You may refuse to sign this acknowledgement **

I, _____, did receive a copy of this office's Notice of Privacy Practices on DATE:_____ .

BELOW LINE FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but it could not be obtained because:

( ) Individual refused to sign
( ) Communications barriers prohibited obtaining the acknowledgement
( ) An emergency situation prevented us from obtaining
( ) Other (please specify)

SIGNATURE: _____ DATE:_____

HIPAACompliance Patient Consent Form

Patient Name:_____

Responsible PartyName:_____

Our Notice of Privacy Practices 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. Weare not required to agree with this restriction, but if we do, we shall honor this agreement. TheHIPAA (Health Insurance Portability andAccountability 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 inwriting, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health 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 patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

SIGNATURE:_____**DATE:**_____

MEDICAL HISTORY FORM

Patient Name:_____ DOB: _____

CONDITIONS

AIDS/HIV	Yes	No	Unsure
Anemia	Yes	No	Unsure
Anxiety	Yes	No	Unsure
Arthritis	Yes	No	Unsure
Artificial Heart Valve/Repair	Yes	No	Unsure
Artificial Joints	Yes	No	Unsure
Asthma	Yes	No	Unsure
Blood Disease	Yes	No	Unsure
Blood Thinners	Yes	No	Unsure
Blood Transfusions	Yes	No	Unsure
Cancer	Yes	No	Unsure
Chemical Dependency	Yes	No	Unsure
Chemotherapy	Yes	No	Unsure
Congenital Heart Disease (CHD)	Yes	No	Unsure
Congestive Heart Failure	Yes	No	Unsure
Coronary Artery Disease	Yes	No	Unsure
Depression	Yes	No	Unsure
Diabetes	Yes	No	Unsure
Dizziness/Fainting	Yes	No	Unsure
Eating Disorder	Yes	No	Unsure
Emphysema/COPD	Yes	No	Unsure
Epilepsy	Yes	No	Unsure
Excessive Bleeding/Bruising	Yes	No	Unsure
Fainting/Seizures	Yes	No	Unsure
Glaucoma or Other Eye Problems	Yes	No	Unsure
Have you ever taken Bisphosphonates?			
	Yes	No	Unsure

If yes, for how long?_____

Hay Fever/Seasonal Allergies	Yes	No	Unsure
Head Injury	Yes	No	Unsure
Heart Attack	Yes	No	Unsure
Heart Disease	Yes	No	Unsure
Heart Murmur/Rhythm Disorder	Yes	No	Unsure
Hemophilia	Yes	No	Unsure
Hepatitis	Yes	No	Unsure
High Blood Pressure	Yes	No	Unsure
Hormonal Replacements	Yes	No	Unsure
Immune Deficiency, Rheumatoid Arthritis	Yes	No	Unsure
IV Medication	Yes	No	Unsure
Jaundice or Liver Disease	Yes	No	Unsure
Kidney Disease	Yes	No	Unsure
Liver Disease	Yes	No	Unsure
Low Blood Pressure	Yes	No	Unsure
Lupus	Yes	No	Unsure
Mental Health Disorder	Yes	No	Unsure
Neurological Disorders	Yes	No	Unsure
Osteoporosis or Paget' Disease	Yes	No	Unsure
Pacemaker/Implanted Defibrillator	Yes	No	Unsure
Persistent Heartburn (GERD)	Yes	No	Unsure
Post-Traumatic Stress Disorder	Yes	No	Unsure
Pre Medication	Yes	No	Unsure
Previous Infective Endocarditis	Yes	No	Unsure
Radiation	Yes	No	Unsure
Respiratory Problems	Yes	No	Unsure
Rheumatic Fever	Yes	No	Unsure
Sinus Problem	Yes	No	Unsure
Stroke	Yes	No	Unsure
Thyroid Problems	Yes	No	Unsure
Tuberculosis	Yes	No	Unsure
Tumors	Yes	No	Unsure
Ulcers	Yes	No	Unsure

Venereal Disease	Yes	No	Unsure

Other Conditions:_____

ALLERGIES

Barbiturates, Sedatives	Yes	No	Unsure
Iodine	Yes	No	Unsure
Latex	Yes	No	Unsure
Local Anesthetics	Yes	No	Unsure
Metals	Yes	No	Unsure
Penicillin or Other Antibiotics	Yes	No	Unsure

Other Allergies: _____

MEDICAL QUESTIONNAIRE

Are you taking any Prescription Medication? Yes No

Please List all Prescription Medications: _____

_____

Do you use any form of Tobacco or Nicotine Products (cigarettes, cigars, snuff, chew, bidis)?

Yes No

Do you use Vaping Products?

Yes No

Do you take any over-the-counter medications, vitamins, herbs and/or supplements?

Yes No

WOMEN ONLY:

Are you taking birth control pills?

Yes No

Are you CURRENTLY pregnant?

Yes No

If yes, number of weeks? _____

Are you nursing?

Yes No

MEDICAL DOCTORS INFORMATION

Primary Medical Doctor's Name:

_____

Primary Medical Doctor's Phone:

_____

What is your normal blood pressure?

_____

Date of last physical examination: _____

PLEASE SELECT YES OR NO FOR ALL OF THE FOLLOWING QUESTIONS:

Are you currently being seen or treated by a physician?

Yes No

Has a physician recommended that you take antibiotics before having dental work done?

Yes No

Do you use a C-Pap machine?

Yes No

Have you had a serious illness, operation or been hospitalized in the past 5 years?

Yes No

Are you developmentally disabled? If yes please list your guardian.

Yes No

Have you had any type (either total or partial) of joint replacement surgery?

Yes No

Have you had a heart valve replacement or heart surgery?

Yes No

Have you had an organ or bone marrow/stem cell transplant?

Yes No

Have you had a fever (100.4F or above) in the last 72 hours?

Yes No

Please describe any “Yes” answers. Write N/A if this does not apply to you.

_____

_____

_____

DENTAL HISTORY & SYMPTOMS

What is the reason for your visit today? _____

_____

Are you experiencing any dental pain or discomfort? If yes, Where? _____

_____

When was your last dental exam? _____

Are you experiencing any of the following symptoms? Mark all that apply.

- ☐ Pain to Chewing
- ☐ Pain to Hot
- ☐ Pain to Cold
- ☐ Spontaneous Pain
- ☐ Constant Pain
- ☐ Dull Throbbing
- ☐ Sharp Stabbing
- ☐ Lingering Pain
- ☐ Radiating Pain
- ☐ Electric Pain

By signing below, I certify that all the above information is true to the best of my knowledge. I understand the importance of this information and that the practice will rely on this information for the treatment. I will not hold the practice or any member / staff of the practice, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient or Responsible Party:_____

Print Patient Name: _____ Date: _____