Premier Dental Care
220 E. Horizon Drive, Suite F
Henderson, Nevada 89015
(702) 565-0000
www.premierdental702.com

CHART # _____
For Office Use Only

REFERRAL INFORMATION

Please mark all that apply

Whom may we thank for referring you?

Family Member_____
Co-Worker_____
Friend_____
Doctor_____
Other _____

Or did you find us on your own?

Our Website	Facebook
Google	Yelp
Banner/Drive By	Mailer/Postcard
Insurance Company	Radio/TV
Other _____	

Dental History

When was your last dental exam? _____ Dental cleaning? _____

Are you happy with the appearance of your teeth?	○ Yes	○ No
Are your teeth all in alignment (straight)?	○ Yes	○ No
Do you like the color of your teeth?	○ Yes	○ No
Do you like the shape of your teeth?	○ Yes	○ No
Do you have spaces that you do not like?	○ Yes	○ No
Are your teeth wearing down on the biting surfaces?	○ Yes	○ No
Have old fillings/dental work you don't like looking at?	○ Yes	○ No

Are your teeth Chipped Protruding Hidden

What would you like to change the most about the appearance of your teeth?

How would you like your teeth to look?

Please check the boxes of all that apply:

Pain or discomfort at this time
Clench or grind your teeth
Gums bleed when you brush
Pain in jaw joints
Headaches: If yes, how often _____
Loose teeth
Broken or chipped teeth /fillings
Bad breath
Smoke or use tobacco
Teeth that trap food between them
Teeth sensitive to: Hot Cold Sweets Biting
Have you ever been treated by: Orthodontist Periodontist

Why did you leave your last dentist?

Please list your sports activities and hobbies.

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Medical History and Information

Are you under a physician's care now? ○ Yes ○ No Reason_____

Have you been hospitalized in the past two years? ○ Yes ○ No Reason_____

Are you taking blood thinners? ○ Yes ○ No Medication_____

Are you taking any other drugs or medications? ○ Yes ○ No Reason_____

Have you had a Hip or Knee Replacement? ○ Yes ○ No Which Joint? Hip Knee ☐ Ankle

Have you ever had any of the following? Please check mark those that apply:

Abnormal Bleeding
Alcohol Abuse
Anemia
Angina Pectoris
Arthritis
Artificial Heart Valve
Asthma
Blood Transfusion
Cancer
Chemotherapy/Radiation Therapy
Colitis
Congenital Heart Defect
Cosmetic Surgery
Diabetes
Difficulty Breathing
Drug Abuse
Emphysema
Epilepsy
Fainting Spells
Fever Blisters
Frequent Headaches
Glaucoma
Hay Fever
Heart Attack
Heart Murmur
Heart Surgery
Hemophilia
Hepatitis A
Hepatitis B
Hepatitis C
High Blood Pressure
Hiv + / AIDS
Infectious Endocarditis
Kidney Problems
Liver Disease
Low Blood Disease
Mitral Valve Prolapse
Pace Maker
Pneumocystis
Psychiatric Problems
Rheumatic Fever
Seizures
Shingles
Sickle Cell Disease
Sinus Problems
Stroke
Thyroid Problems
Tuberculosis
Ulcers
Venereal Disease
Yellow Jaundice

Allergies:

Amoxicillin/Penicillin
Aspirin
Codeine
Dental Anesthetics
Erythromycin
Jewelry
Latex
Metals
Sulfa
Tetracycline

Other Allergies:

For Women, Are you: Taking Birth Control Pregnant - # of Weeks_____ Nursing

Do you have or have you had any condition or problem not listed above? ○ Yes ○ No

Explain:

To the best of my knowledge, all the preceding answers are correct. If I have any changes in my health status or if my medicines changes, I will inform the dentist and staff before the next appointment.

SIGNATURE: _____ DATE: _____

FOR OFFICE USE: Reviewed by _____ DATE: _____

MEDICAL UPDATES

I have read my medical history above and confirm that it adequately states past and present conditions.

DATE CHANGES SIGNATURE REVIEWED BY

_____

_____

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Patient Information

Patient Name Last _____First_____ Initial ___ Preferred Name _____
Birth Date_____ Soc. Sec. # _____ ○ Male ○ Female Marital Status: Select
Address _____ Apt. _____City _____State____ Zip Code_____
Phone (Home) _____ (Cell) _____ (Work)_____Ext:_____
E-Mail Address_____ Receive Text Message Reminders ○ Yes ○ No
Employer _____ Position _____
Employer Address _____ City _____ State ____ Zip _____
Medical Physician_____ Phone Number _____
Previous Dentist_____ Phone Number _____
Parent/Spouse's Name_____Phone_____
Emergency Contact_____Relationship_____Phone_____

Responsible Party Information

The following is for: ○ Parent/Guardian ○ Patient's Spouse ○ Not Applicable-Same as above
Name Last _____First _____Initial ____ Relationship to Patient Select
Birth Date _____ Social Security #_____ Phone _____
Address _____ Apt. ___City _____State____ Zip Code_____
Employer _____ Occupation _____

Primary Dental Insurance Information

Name of Insured _____ Relationship to Patient Select
Insured's Birth Date_____ Social Security #_____ Phone _____
Insurance Co._____ Employer_____

Secondary Insurance Information

Name of Insured _____ Relationship to Patient Select
Insured's Birth Date_____ Social Security #_____ Phone _____
Insurance Co._____ Employer_____

HIPPA Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your (PHI) information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and disclosures of Protected Health Information

Your protected health information may be used and disclosed by a physician, our office staff, and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conduction arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may also use or disclose your name, photograph, and email address in order to obtain a LumiSmile picture. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required by Law, Public Health issues as required by law, Communicable Diseases: Health oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal proceedings: Laws Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of health and human services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and required Uses and Disclosures will be made only with your consent, Authorization or Opportunity to object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use of disclosure indicated in the authorization.

Your Rights

Following is a statement of your rights with respect to your protected health information.

You have the right to request a restriction of your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment, or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care for notification purposes as described in this Notice of Privacy practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If your physician believes it is in your best interest to permit use and disclosure of your protected health information, it will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint**.

This notice was published and becomes effective on / or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our (702) 565-0000.

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Acknowledgement of Receipt of Notice of Privacy Practices

Signature below is only acknowledgement that you have received the Notice of our Privacy Practices. You may request a copy of our Notice of Privacy Practices if you would like it in writing:

Print Name: _____ Signature: _____ Date: _____

Please provide the following information if you would like to authorize our office to release your information: (optional)

I, _____, authorize the release of treatment and financial records

pertaining to _____ (patient name) to the following people:

_____Relationship_____

_____Relationship_____

_____Relationship_____

Print Name: _____ Signature: _____ Date: _____

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TO OUR VALUED PATIENT:

Thank you for choosing us as your dental care provider. We are committed to providing you with the best care possible. In order to achieve this goal, we need your assistance and your understanding of our financial policies. If you have any questions or concerns regarding these policies, please feel free to ask any of our staff. If you would like a photocopy of this outline, please ask. Please understand the following:

1. Payment for services is due at the time services are rendered. We accept Cash, Checks, Visa, MasterCard, Discover, American Express, CareCredit, and Springstone Financing. As a courtesy, we will submit an insurance claim on your behalf if you show proof of coverage. If your insurance company/coverage changes, please notify us immediately.

2. DENTAL INSURANCE: Our office will gladly work with you to help get the maximum benefit available to you. Most dental insurance plans do not cover 100% of your cost of treatment. Therefore, you will be expected to pay your deductible and your *estimated* co-payment on the day services are rendered. We will gladly file your insurance claim. Many variables exist from carrier to carrier (i.e. deductibles, annual maximums, allowable fee limitations, non-covered procedures, and other restrictions); therefore, we cannot guarantee any estimated charges. Because your insurance is an agreement between you and the insurance company, ultimately you are responsible for all charges whether the insurance company pays or not. You are responsible for knowing your insurance benefits. Please know that we will do everything possible to see that you receive the full benefits from your insurance company. If for some reason your insurance company has not paid their estimated portion within 60 days from the start of treatment, you are responsible for payment in full at that time. We expect prompt payment from you within 15 days of statement received for any balance due after insurance pays. Treatment could be altered if your dental needs change. The patient will be notified of any change(s) in treatment.

3. Any balance due on account over 120 days without payment arrangements will be turned over to the collection agency representing our office. In the event your account is sent to a collection agency, you will be responsible for any collection fees, legal fees, or court costs.

4. Payment and co-pays for treatment (crowns, bridges, partials, and dentures) are due on the day services are rendered before we begin treatment.

5. Returned checks are subject to a $25 returned check fee.

6. We respectfully ask that you give us a minimum of 24 hours notice to cancel or reschedule your appointment. Please help us serve you better by keeping scheduled appointments. We reserve the right to charge $25 per hour for appointments cancelled or broken without 24 hours advance notice.

7. No minor children (under the age of 18 yrs old) will be treated without a parent present at all times.

8. The VIP referral credit of $25 will only be applicable and applied to your account if the person you are referring brings in a referral card at the time of their first visit with your name on it.

AUTHORIZATION & RELEASE: I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to myself or my dependent during the period of such dental care to third party payers and/or healthcare practitioners. I authorize and request my insurance company to pay directly to the dentist the amount due on my claim for services rendered to myself or my dependent. I understand that my insurance carrier may pay less than the actual bill for service; and if the nature of the liability were such that it is not covered by the policy, I agree to be responsible for payment of all services rendered on my behalf or my dependents.

I agree to have any photos taken of me to be used for education, training, and/or marketing.

I have read the above conditions of treatment and payment and agree to their content.

Select

_____	_____	_____
Signature of Patient, Parent, or Guardian	Date	Relationship to Patient