Today's Date ____________ Updates ____ | ____ | ____ | ____ | ____ | ____

PATIENT INFORMATION

Patient Name ____________ Date of Birth ____________ Age ______

Address ____________ City ____________ State ______ Zip ______

Home Phone ____________ Cell Phone ____________ SSN ____________

Employer ____________ Address ____________ Phone ____________

Nearest Relative ____________ Address ____________ Phone ____________

Email Address ____________ Referred by ____________

(Insurance List, Friends Name, Yellow Pages, etc.)

SPOUSE OR RESPONSIBLE PARTY *(Circle One or Both)*

Name ____________ Date of Birth ____________ Age ______

Address ____________ City ____________ State ______ Zip ______

Home Phone ____________ Cell Phone ____________ SSN ____________

Employer ____________ Address ____________ Phone ____________

HEALTH QUESTIONNAIRE *(Please indicate if you have or have had any of the following. Check or circle where applicable)*

- ☐ **Taking Blood Thinners / Aspirin**
- ☐ Glaucoma
- ☐ History of Drug Dependency
- ☐ Tuberculosis
- ☐ Currently Pregnant
- ☐ Cardiac Pacemaker
- ☐ **Heart Attack**
- ☐ Kidney / Liver Disease
- ☐ **Heart Defect**
- ☐ History of Steroid Therapy
- ☐ **Heart Valve Replacement**
- ☐ Asthma
- ☐ **Heart Surgery**
- ☐ Osteoporosis Medication
- ☐ Surgery for Artificial Parts
- ☐ Sinus Problems
- ☐ **Joint Replacement**
- ☐ Epilepsy
- ☐ **High Blood Pressure**
- ☐ Emphysema
- ☐ **Bleeding Disorder**
- ☐ Thyroid disease
- ☐ Stroke / Aneurysm
- ☐ **Hepatitis**
- ☐ Cancer or History of Cancer
- ☐ **AIDS / HIV**
- ☐ Radiation therapy
- ☐ **I.V. Cancer Medications**
- ☐ Diabetes
- ☐ **Paget's Disease**

Are you taking any **medications** and/or **required medications**? . . . . **YES / NO**
If so, please list ____________

Are you **allergic** to any medications or materials *(penicillin, latex, epinephrine, fluoride, etc.)*? . . . . **YES / NO**
If so, please list ____________

Do you have any disease, condition or problem **not listed** on this form? . . . . **YES / NO**
If so, please explain ____________

Do you use tobacco products? . . . . **YES / NO**
If so, what and how much? ____________

Have you ever been instructed by a physician to **pre-medicate with antibiotics** prior to dental treatment? . . . . . . **YES / NO**

CONSENT FOR TREATMENT:

I authorize the dentist, and/or other dental providers consent to perform the treatment and whatever procedures may be deemed necessary or advisable in addition to the planned treatment. I understand that there could be complications in connection with the dental procedures such as swelling, bruising, infection, tingling and/or numbness of the lips, tongue, gums, and/or face, which may be permanent; damage to root or tooth in sinus; oral antral fistual; maxillary sinusitis; and post operative hemorrhage and discomfort. I agree to the use of local anesthetic, sedation and analgesia depending on the judgment of the dentist. I understand that there are possible complications, risks and benefits of treatment, anesthesia, other drugs and medication. I have answered this form to the best of my knowledge and have had all my questions answered to my satisfaction. I authorize treatment and the payment of insurance benefits to the practice.

____

Patient or Authorized Person's Signature **Date**

Desert Valley DENTAL

Desert Valley Dental will not disclose any information about you or your account to any individual without written consent.

HIPAA AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

This authorization for use or disclosure of Protected Health Information is intended to satisfy the requirements of the Health Insurance Portability and Accountability Act ("HIPAA") [42 C.F.R. § 164.500 *et seq.*]

Please review and complete the authorization carefully. Failure to provide all the requested information may invalidate the authorization.

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, ____________________, hereby authorize Desert Valley Dental to use my protected health information
Name of Patient

Disclosures to friends and family members:
Do you want to designate a family member or other individual with whom the provider may discuss your medical condition? **Yes or No** (please circle one)
if Yes, Whom?
I give permission for all my Protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below:

Name	Relationship	Contact Number

Desert Valley Dental may disclose detailed dental and health care information to the following
Please check all that may apply:

- ❑ Leave message on home answering machine __________________
- ❑ cell phone __________________
- ❑ work ____________________
- ❑ E-mail _____________________________
- ❑ Office may leave message with above mentioned family members
- ❑ Office should only speak to patient

PATIENT RIGHTS:

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to Desert Valley Dental. I understand that a revocation is not effective to the extent that Desert Valley Dental has relied on the use or disclosure of the protected health information.

Desert Valley Dental will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure, unless as otherwise specifically allowed by law.

I understand that HIPAA prohibits the recipient of my health information from making further disclosures of it without obtaining an additional authorization from me, except in cases in which a further disclosure is permitted or required by law.

I understand that I have a right to receive a copy of this authorization upon my request. In addition, if Desert Valley Dental has sought this authorization, I must be provided with an executed copy of the authorization, whether or not I specifically request one.

SIGNATURE

____
Signature of Patient or Personal Representative

____
Date

____
Print Name of Patient or Personal Representative

If signed by a Personal Representative of the Patient, describe the representative's authority to act for the patient:

____

____

Informed Consent for Controlled Substance Therapy for Pain

In Nevada, per Assembly Bill 474, prescribers must inform their patients of information regarding the treatment of pain with the use of a controlled substance. It is important that you review the following information carefully and request additional information you may need to make an informed choice about the mediation(s) prescribed. Please review the information listed here and initial each item.

Initial:

____ I understand that I am being prescribed medications, including controlled substances for the treatment of pain.

____I understand that all pain medications, including controlled substances, have different benefits and risks in the treatment of my symptoms. I have been advised of the potential risks and benefits of treatment using controlled substances.

____I understand that prescription controlled substances can carry serious risks of addiction and overdose, especially with prolonged use.

____I understand that I am not to use the controlled substance prescribed to me in conjunction with drugs or alcohol, or other medications (unless otherwise directed by my prescriber.)

____Before I was prescribed the pain medication, I was advised regarding non-opioid alternative means of treatment for my symptoms, including but limited to anti-inflammatories (i.e., Aleve, Tylenol, Ibuprofen, etc.).

____I understand that when I take controlled substances(s), it may not be safe for me to drive a car, operate machinery, or take care of other people. I feel sedated, confused or otherwise impaired by these medications, I understand that I should not do things that would put myself or other people at risk for being injured.

____I understand that when I take controlled substances, I may become physically dependent on them, meaning my body will become accustomed to taking the medications every day, and I would experience withdrawal sickness if I stop them or cut back on them too quickly. Withdrawal symptoms feel like having the flu, and may include abdominal pain, nausea, vomiting, diarrhea, sweating, body aches, muscle cramps, runny nose, yawning, anxiety, and sleep problems.

____I understand that I may become addicted to controlled substances and require addiction treatment if I cannot control how I am using them, or if I continue to use them for a prolonged period of time. I have discussed with my prescriber the proper use of the controlled substance.

____I understand that anyone can develop an addiction to pain medications, but people who have had problems with mental illness or with controlling drug or alcohol use in the past or who have a parent or sibling who has had drug or alcohol abuse problems are at higher risk. I have told my prescriber if I or anyone in my family has had any of these types of problems.

____I understand that I must store prescriptions in a secure place and out of the reach of children, other family members and others and/or use a locked medicine cabinet. I safely dispose of unused medications, I can return the unused medications in the bottle to a local pharmacy, a local drug-take back day, or a local police or sheriff substation in my community, or I may safely dispose of them by dissolving them in a Dettera pouch. I understand that I am not to dispose of unused medications into the toilet or sink.

____I understand that my doctor may not be permitted to refill my medication via telephone and, therefore, any requests for refills may require a consultation appointment. I understand that my doctor may decline to refill my prescription if s/he believes it to be medically unnecessary and/or harmful to my well-being. I understand that I am being prescribed a controlled substance for a short duration and that prescriptions for additional periods of time may require additional consultation, assessment and agreements.

____I understand that due to risk of possible overdose resulting from controlled substances, the opioid overdose antidote naloxone (Narcan) is now available without a prescription. I may obtain naloxone (Narcan) from the pharmacist.

____For Women: It is my responsibility to tell my prescriber immediately if I think I am pregnant or if I am thinking about getting pregnant. I understand the risk to a fetus of chronic exposure to controlled substances during pregnancy, including, without limitation, the risks of fetal dependency on the controlled substance, neonatal abstinence syndrome, neurologic and heart problems in the baby, prematurity, and fetal or neonatal death.

Informed Consent:

I understand each of the statements written here and by signing give my consent for treatment of my pain condition with medications, including controlled substances. I have had the opportunity to ask any questions that I may have regarding my treatment of pain with medications, including controlled substances, and am satisfied that my questions have been answered.

______________________ ______________________ ___________

Patient Name Printed   Patient Signature   Date

Un-emancipated Minor

As the Parent/Guardian, I have discussed with the prescriber the risks that the minor will abuse or misuse the controlled substance or divert the controlled substance for use by another person and ways to detect such abuse, misuse or diversion.

______________________ ______________________ ___________

Parent/Guardian Name printed   Parent/Guardian Signature   Date

Welcome to the Dental Practice of Desert Valley Dental

Patient Financial and Privacy Policies

PAYMENT IS DUE IN FULL AT THE TIME OF SERVICE UNLESS YOU ARE AN *ESTABLISHED* PATIENT OF RECORD AND ONE OF THE FOLLOWING OPTIONS APPLIES AND IS SELECTED.
Established: Full exam and full mouth x-rays

____ 1. (*For Established Patients without or not utilizing Insurance.) I choose to pay my balance in full at time of service and take advantage of a 10% courtesy discount.

____ 2. (*For Established Patients with Insurance.) I choose to pay my estimated portion at each appointment. I understand that any remaining balance not paid by my dental insurance is my responsibility to pay in full within 30 days of insurance receipt or denial.

____ 3. I choose to use CareCredit® for any services over $300 and take advantage of their 0% interest programs. (Subject to Credit Approval)

REGARDING INSURANCE:

We will gladly process your insurance claims, estimate your deductible and portion not covered by your insurance plan. The estimated amount not covered by your insurance is due at the time of treatment. Our estimates are not a guarantee of coverage or benefits and should not be taken as such. The balance is your responsibility whether your insurance pays it or not. If you have dual insurance we will bill the secondary insurance after primary payment has been received. We do this as a courtesy for you. However, you should be aware that many secondary insurance plans no longer cover amounts unpaid by your primary insurance. Therefore, patients must pay the estimated amount not covered by the primary insurance at the time of service.

REGARDING APPOINTMENTS AND CANCELLATIONS:

When we make your appointment, we are reserving a room for your particular needs. We ask that if you must change an appointment, please give us at least 24 hours notice. This courtesy makes it possible to give your reserved room to another patient who would like it.

We feel that our patient's time is valuable. When your appointment is made, your records are prepared, and special instruments are readied for your visit. Except for an emergency, we pride ourselves for being on time and prompt, so we would appreciate the same courtesy from our patients. We are proud to be part of a team whose primary goal is to provide the finest and most comprehensive dental care available today. It is important that you read and understand our office policy and ask any questions you may have regarding any of the following.

There is a $50 Charge for not showing up for scheduled appointments, and or canceling with less than 24 hours notice. Repeated cancellations or missed appointments will result in loss of future appointment privileges.

REGARDING PAST DUE AND DELINQUENT ACCOUNTS:

We will charge 1.58% MPR and 18.96% APR for all accounts over 90 days past due.

In case it becomes necessary to hire an outside collection agency to collect money owed on accounts over 90 days, your balance will be increased by 40% to 50% to cover all collection/small claims court costs.

I, ________________________ authorize Desert Valley Dental, to examine and provide dental treatment. I authorize my insurance company to pay by check made out directly to Desert Valley Dental. I authorize Desert Valley Dental to release any medical, dental or incidental information that may be necessary for either dental care or in processing applications for financial reimbursement. I understand that it is my responsibility to know all the rules and restrictions of my insurance policy, to know which hospitals, emergency rooms, laboratories, x-ray departments, and specialists which are assigned to me according to my insurance policy rules. It is Desert Valley Dental's office procedure to share Protected Health Information with labs, consulting physicians, and hospitals. We will phone the pharmacy of your choice regarding your prescriptions. Only the minimum necessary Protected Health Information for each transaction will be exchanged. A copy of our notice of privacy practices is available upon request.

X____ Date__________
Signature of Patient, Responsible Party or Legal Guardian