Summerlin Smiles
GENERAL AND COSMETIC DENTISTRY

9525 W. Russell Rd. Suite 100
Las Vegas, NV 89148
Phone: (702)579-7645
SummerlinSmilesLV@gmail.com

Patient Information

Patient Name: _____
Last Name First Name MI (Preferred Name)

Birth date: _____ Gender: _____ Marital Status: _____

Social Security #: _____ Email Address: _____

Phone (Home): _____ (Cell): _____

Address: _____
Street (Apartment #)

_____
City State Zip Code

Health Information

Date of Last Dental Visit: _____ Reason for this visit: _____

Have you ever had any of the following? Please check applicable boxes:

- ☐ AIDS/ HIV
- ☐ Allergies _____
- ☐ Codeine Allergy
- ☐ Penicillin Allergy
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Bloody Nose (Persistent or Currently))
- ☐ Recurring Body Ache
- ☐ Cancer
- ☐ Recurring Cough
- ☐ Recurring Chill
- ☐ Diabetes Type_____
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Fever Currently
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Persistent Headaches
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis_____
- ☐ High Blood Pressure
- ☐ HIV
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Night sweats (Persistent or Currently)
- ☐ Pacemaker
- ☐ Are you pregnant
  Due date: _____
- ☐ Radiation Treatment
- ☐ Respiratory condition
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Runny/Stuffy Nose (Currently)
- ☐ STI
- ☐ Sinus Condition
- ☐ Stomach Condition
- ☐ Stroke
- ☐ Sore throat (Currently)
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Thyroid condition
- ☐ Ulcers
- ☐ Unexplained weight loss

OTHER:
- ☐ _____
- ☐ _____
- ☐ _____

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you now under the care of a physician? ☐ Yes ☐ No Name & Ph# of Physician: _____
  If yes, please explain: _____
- List of medications: _____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ Date: _____
Signature of patient, parent/guardian, or responsible party

Referral Information

Name of person or office referring you to our practice: _____

☐ Another Dental Office ☐ Yelp ☐ Insurance Company ☐ Other _____

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Employment Information

Employer Name_____ Occupation: _____

Address:_____
Street City, State Zip Code Phone

Responsible Party Information

PLEASE FILL OUT IF PATIENT IS UNDER 18 YEARS OF AGE:

Name of Responsible Party: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Insurance Information

Primary Insurance

Name of Subscriber: _____
Subscriber's Date of Birth: _____
Subscriber's Employer: _____

Patient's relationship to insured:
☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Name: _____
ID #: _____
Group #: _____
Insurance's Mailing Address:

_____
Street City State Zip Code

Secondary Insurance

Name of Subscriber: _____
Subscriber's Date of Birth: _____
Subscriber's Employer: _____

Patient's relationship to insured:
☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Name: _____
ID #: _____
Group #: _____
Insurance's Mailing Address:

_____
Street City State Zip Code

COLLECTION POLICY

ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize and request my insurance company to pay directly to the Doctor the amount due on my claim for services rendered to me or my dependents. I further agree that should the amount be insufficient to cover the entire dental expense incurred, I will be responsible for payment of the difference; and if for any reason that it is not covered by the policy, I will be responsible to the Doctor for payment of the entire bill. In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay any unpaid balance by my insurance company. For any reason, that I cannot pay my balance in full, financial arrangements must be made between myself and the dental office. I oblige to all financial arrangements made and understand that a finance charge of $10 per month will be applied to my balance if any deviations occur from the financial agreement between me and the dental office.

RETURNED CHECKS: A $25 returned check fee will be charged for each check returned unpaid by your bank. If such should happen, we will only accept payments by cash, money order, or credit card. If you fail to make full restitution for an NSF check, pursuant to NRS 205.130, we are obligated to submit your information to the Clark County District Attorney for legal penalties.

COLLECTIONS: If it should be necessary to initiate legal proceedings to collect any unpaid amount, I will be responsible for all collection fees (25% of the unpaid amount) and/or legal fees (50% of the unpaid amount) incurred in the process.

I understand and agree to pay a $25 cancellation fee for any appointments cancelled with less than 24 hours notice.

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

_____ Date: _____ Relationship to Patient: _
Signature of guarantor of payment/responsible party

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Attendance Policy

This attendance policy is to ensure your success in your oral health. The more consistent and committed you are to attending your scheduled appointments, the healthier your oral health will be.

Confirmation Reminders
As a courtesy to our patients, reminder texts and/or emails are usually sent once appointments have been made, a month prior to the appointment, a one-week reminder, and a three-day reminder. Patients can confirm via text by responding with "C" to confirm or the confirm button in the email. If there is no response from the patient via text or email, courtesy call is made two days prior to the scheduled appointment. It is the patient's responsibility to confirm via text, email, or call to our office 48-hours before the scheduled appointment. If the appointment is not confirmed by the final courtesy call, then the scheduled appointment is subject to cancellation.

If patients would like to receive text messages, it is the patient's responsibility to opt in to be able to receive the notifications. If the patient accidentally opted out of the text, it is the patient's responsibility to let the office know to opt them back in.

If any contact information for the patient changes, it is the patient's responsibility to update new information with our office. (See other side of page to update contact information.) Summerlin Smiles is unable to provide a guarantee of maintaining a patient's appointment if contact information on file is not updated by the patient or responsible party.

Cancellations
It is preferred to have a 24-hour notice for cancellation so we can accommodate all patients. The attendance policy applies to patients who cancel their appointment within less than 24-hours of the scheduled appointment time. This policy does not apply for any cancellation notice given within more than 24-hours. We understand illnesses are unpredictable, so we require a minimum of 2-hour notice for sick or emergency cancellations.

No Show Policy
A no-show is when a patient gives no notice in advance. A no-show is considered a missed appointment. There is a $25 per missed/cancelled appointment fee per each family member.

After three missed appointments within a year, all appointments will now be same day appointments only. Patients can call on the day they are available to see what openings our office may have.

We value our time spent with each patient and appreciate your willingness to cooperate with our cancellation policy.

I have read the Attendance Policy and will do my part to show up regularly and on time:

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Privacy & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow- up among the multiple health care providers who may be involved in that treatment directly and indirectly
- Obtain payment from third – party payers
- Conduct normal health care operations such as quality assessments and physician certifications.

I have received, read, and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions but if you do agree you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

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PATIENT CONSENT TO TREATMENT

DRUGS, MEDICATIONS, AND ANESTHESIA:

I understand that antibiotics, analgesics, and other medications may cause adverse reactions, some of which are, but are not limited to, redness and swelling of tissues, pain, itching, vomiting, dizziness, miscarriage, cardiac arrest.

I understand that medications, drugs and anesthetics may cause drowsiness and lack of coordination, which can be increased by the use of alcohol and drugs, I have been advised not to consume alcohol, nor operate any vehicle or hazardous device while taking medications and / pr drugs, or until fully recovered from there effects (this includes a period of a t lease twenty-four [24] hours after my release from surgery.)

I understand that occasionally, upon injection of local anesthetic, I may have prolonged, persistent anesthesia, numbness, and / or irritation to the areas of injections.

I understand that If I select to utilize Nitrous Oxide, "Atarax", Chloral hydrate, "Xanax", or any other sedative, possible risks include, but are not limited to, loss of consciousness, obstruction of airway, anaphylactic shock, and cardiac arrest, I understand that someone needs to watch me closely for a period of 8 to 10 hours, following my dental appointment, to observe for possible deleterious side effects, such as obstruction of airway.

Initial ____

HYGIENE AND PERIODONTICS (TISSUE AND BONELOSS):

I understand that the long-term success of treatment and status of my oral condition depends on my efforts at proper oral hygiene (i.e. brushing and flossing) and maintaining regular re-call visits.

PERIODONTICS –If diagnosed by the doctor, I understand that I have a serious condition, causing gum and bone inflammation and/ or loss, and that it can lead to loss of my teeth and other complications, the various treatment plans have been explained to me, including gum surgery, replacements and / or extractions, I also understand that although these treatment have high degree of success, they cannot be guaranteed, occasionally, treated teeth may require extraction.

Initial ____

I UNDERSTAND THAT NO GUARANTEE OR ASSURANCE HAS BEEN GIVEN OR THAT THE PROPOSED TREATMENT WILL BE CURATIVE AND / SUCCESSFUL TO MY COMPLETE SATISFACTIONS. I AGREE TO COOPERATE COMPLETELY WITH THE RECOMMENDATIONS OF THE DOCTOR WHILE I AM UNDER HIS/ HER CARE, REALIZING THAT ANY LACK OF IT COULD RESULT IN LESS THAN OPTIMUM RESULTS.

I CERTIFY THAT I HAVE HAD AN OPPORTUNITY TO READ AND FULLY UNDERSTAND THE TERMS AND WORDS WITHIN THE ABOVE AND CONSENT TO QUESTIONS, AND HAVE HAD THEM ANSWERED TO MY SATISFACTION.

I UNDERSTAND THESE DENTAL SERVICES ARE PROVIDED WITHOUT DISCRIMINATION BASED ON RACE, RELIGION, COLOR, NATIONAL ORIGIN, SEX, SEXUAL ORIENTATION, PHYSICAL OR MENTAL DISABILITY, AGE OR MARITAL STATUS AND PROTECT THE PRIVACY OF EACH OF ITS PATIENTS.

Signature _____**Relationship** _____ **Date**_____

Patient, guardian, or legal representative

OFFICE USE:

Doctor Signature _____ Witness _____

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Opiod Risk Assessment

Patient Name: _____ Date of Birth:_____

	Circle all that applies to you
Are you between the age of 16-45 years?	Yes
Do you have a history of preadolescent sexual abuse?	Yes
PERSONAL HISTORY **Have you had a history of abuse of the following:**	
Alcohol?	Yes
Illegal Drug?	Yes
Prescription Drugs?	Yes
Do you suffer from any of the following:	
ADD, OCD, bipolar, schizophrenia?	Yes
Depression?	Yes
FAMILY HISTORY **Has anyone in your family abused any of the following:**	
Alcohol?	Yes
Illegal Drug?	Yes
Prescription Drugs?	Yes

To the best of my knowledge, all the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors.

_____ _____

Patient/Guardian Signature Date