COMPLETE DENTAL

PATIENT INFORMATION

Patient Name: ___________________________ Date of Birth:______________ Age_________ Sex_______

Address:___________________________ City______________ State__________ Zip Code__________

Mailing Address (if different):___________________________ Zip Code__________

Phone#: ______________ Cell Phone#:______________ Email:______________

Emergency Contact:______________ Phone#:______________ Relationship to patient:______________

-If you are filling out this form for the patient: Your name:______________ Relationship to patient:______________

INSURANCE Do you have: ☐ 1 Insurance ☐ 2nd Insurance ☐ Medicaid ☐ Cash (no insurance)

If you have insurance, did you give your information to Complete Dental? ☐ Yes ☐ No If not, please give the receptionists your insurance information

Plan Subscriber name:______________ Subscriber Social Security#:______________

DENTAL HISTORY

How many times a day do you brush your teeth?_________ How many times a day do you floss your teeth?_________

Date of last dental exam: ______________ Date of last dental x-rays:______________

Describe your dental problems that brought you to our office today:______________

-Do you smoke or chew tobacco? ☐ Yes ☐ No If yes, how frequent and how much?______________

MEDICAL HISTORY

(CHECK ALL THAT APPLY)

- ☐ Heart problems
- ☐ Pacemaker
- ☐ Heart attack
- ☐ Mitral valve prolapse
- ☐ Heart murmur
- ☐ Taking heart medication
- ☐ Rheumatic fever or rheumatic heart disease
- ☐ Stroke
- ☐ Irregular Heartbeat
- ☐ High Cholesterol
- ☐ High/low blood pressure
- ☐ Blood Problems
- ☐ Abnormal bleeding
- ☐ Had a blood transfusion
- ☐ Anemia
- ☐ Hepatitis **What type?** __________
- ☐ HIV/AIDS
- ☐ Herpes **genital/or labial- What type?**__________
- ☐ Diabetes
- ☐ Family history of Diabetes
- ☐ Epilepsy/ seizures
- ☐ Bone problems
- ☐ Artificial joint **Year :**__________
- ☐ Major Operation:__________
- ☐ Arthritis
- ☐ Kidney disease
- ☐ Cancer o tumor
- ☐ Tuberculosis
- ☐ Under medical care?
- ☐ Drink Alcohol? **How much?**_______

-Do you have another condition not mentioned above? ☐ Yes ☐ No List it here:______________

-**Do you take anticoagulants** Blood Thinners? ☐ Yes ☐ No Does your Doctor direct you take antibiotics or other medications before your dental appointments? ☐ Yes ☐ No

-Last Visit to your Doctor?______________ Doctors name and phone#:______________

-List medications you are taking: ______________

ALLERGIES: ☐ Penicillin ☐ Aspirin ☐ Codeine ☐ Sulfa ☐ Acrylic ☐ Metal ☐ Latex ☐ Sedatives

☐ Local anesthetics ☐ Other Allergies:______________

Women: -Are you pregnant? ☐ Yes ☐ No how many months?_________ -Are you taking oral contraceptives? ☐ Yes ☐ No

- Are you breastfeeding? ☐ Yes ☐ No -Have you reached menopause? ☐ Yes ☐ No Symptoms:______________

Patient or parent/representative **signature**:______________ Date:______________ Doctor Initials:__________

CONSENT FOR EMAILS OR TEXT MESSAGES

Patients in our practice may be contacted via email and/or text messaging to remind you of appointments, to obtain feedback on your experience with our dental team, and to provide general health reminders/information.

Please provide an email address that you consent to receive emails at:______________

Please provide a phone number that you consent to receive text messages at:_(_______)__________-______________

Check here if you would **NOT** like to receive emails. . . . . ☐ Check here if you would **NOT** like to receive text messages. . . . . ☐

Patient or parent/representative **signature**:______________ Date:______________

NOTICE OF APPOINTMENT CANCELLATIONS

We reserve appointment time to properly serve you and our other patients. If you are not able to keep your appointment and need to cancel please contact us at least 24 hours before. This advanced notice allows us to serve other patients by placing them into the time slot. Not doing so will result in a $25.00 charge per hour lost by the patient. The patient is responsible for this charge as it will not be billed to the insurance.

I have read and understand the Notice of Appointment Cancellations

Patient or parent/representative **signature**:____ Date:____________________

FINANCIAL AGREEMENT

Whether I have insurance or do not have dental insurance I accept that all payments and co-payments are due at the time of treatment, unless prior arrangements have been made. I agree that I am responsible for all fees and services rendered to me. I accept financial responsibility for all charges not covered by my dental insurance.

I understand that I am responsible for my balance if the following happens:

- I have no insurance or my insurance contract terminated.
- I prevent or delay insurance payments by not meeting the required signatures or requirements on forms.
- I do not finish my treatment resulting in my insurance not paying for the treatment.
- I receive the check for my treatment from the insurance and do not send it to Complete Dental.
- My insurance doesn't pay my treatment as estimated leaving me with a balance.
- My treatment exceeds the amount covered annually.
- I'm not eligible for dental benefits.
- Lab costs accumulate because of missed appointments.
- My insurance denies any treatment.

Patient or parent/representative **signature**:____ Date:____________________

HIPAA ACKNOWLEDGEMENT

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT FOR DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Patient name:____ Phone number#:____

Address:____

Date of Birth:____________________ Sex: Male / Female Social Security#:___________________________

SECTION B: TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

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 our 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.

Office Contact Information:
Complete Dental
Jong S. Jin D.D.S
2625 S. Rainbow Blvd., Ste D-100
Las Vegas, NV 89146
Phone: (702)227-5800 Fax: (702)227-5801

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, and that we may decline to treat you or to continue treating you if you revoke this Consent

I, ____, have had full opportunity to read and consider the contents of this Consent form and your 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 healthcare operations.

SIGNATURE:____ DATE:________________________________

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name:____ Relationship to Patient: ___________________________

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.