GETTING TO KNOW YOU AS OUR PATIENT

Who may we thank for referring you to our office?		TODAY'S DATE
PATIENT FULL NAME	SOCIAL SECURITY # (used to verify Insurance)	DATE OF BIRTH
ADDRESS	CITY, STATE, ZIP	☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Male ☐ Female ☐ Minor (please fill out Responsible Party section)
CELL PHONE	OTHER PHONE	Best phone number to reach you for communication about your dental appointments ☐ Cell ☐ Home ☐ Work ☐ Other
HOME PHONE	WORK PHONE	EMAIL ADDRESS
OCCUPATION	EMPLOYER NAME & ADDRESS	

RESPONSIBLE PARTY	SOCIAL SECURITY # (used to verify Insurance)	DATE OF BIRTH
ADDRESS ☐ Same as above	CITY, STATE, ZIP	RELATIONSHIP TO PATIENT

PRIMARY DENTAL INSURANCE COMPANY	GROUP NAME & NUMBER	SUBSCRIBER NAME, MEMBER ID & DOB
SECONDARY DENTAL INSURANCE COMPANY	GROUP NAME AND NUMBER	SUBSCRIBER NAME, MEMBER ID & DOB

Date of last dental visit: _____/_____/_____

Reason for today's visit: _____

_____

DENTAL HISTORY: Please check ALL that apply to your dental health.

- ☐ I brush daily
- ☐ I floss _____ per week
- ☐ I avoid dental treatment due to anxiety
- ☐ I am unhappy with the appearance of my teeth
- ☐ I avoid brushing part of my mouth due to pain
- ☐ My gums feel tender or swollen
- ☐ My gums bleed while brushing or flossing
- ☐ I have pain around my ear
- ☐ I have problems with food collection in my teeth
- ☐ I have blisters on my lips or mouth
- ☐ I clench or grind my teeth during the day/while sleeping
- ☐ I have loose teeth
- ☐ I have broken teeth/fillings
- ☐ I have sores/growths in my mouth
- ☐ I have had periodontal treatment
- ☐ I have a dry mouth
- ☐ I have a burning sensation on my tongue
- ☐ I have sensitivity to cold
- ☐ I have sensitivity to heat
- ☐ I have sensitivity to sweets
- ☐ I have sensitivity when biting/chewing
- ☐ I have had a facial or jaw injury
- ☐ My jaw clicks/pops
- ☐ I have jaw pain
- ☐ I smoke cigarettes / pipe
- ☐ I use chewing tobacco
- ☐ Other concern(s)_____

7520 W. Washington Ave., Ste. 120, Las Vegas, NV 89128, Phone: 702-363-1590

Physician's Name & Phone Number:_____

MEDICAL HISTORY: Have you ever been diagnosed with or treated for any of the following conditions? (Please check ALL that apply.)

☐ Allergies	☐ Dizziness	☐ Heart Attack - Year _____	☐ Low Blood Pressure	☐ Stomach Problems
☐ Anemia	☐ Emphysema	☐ Heart Disease	☐ Lupus	☐ Stroke - Year _____
☐ Arthritis	☐ Epilepsy	☐ Heart Murmur	☐ Nervous Disorders	☐ Tuberculosis
☐ Artificial Bones/Joints	☐ Endocarditis	☐ Hemophilia	☐ Pacemaker	☐ Tumors/unexplained growths
☐ Artificial Heart Valves	☐ Excessive/Abnormal Bleeding	☐ Hepatitis Type:_____	☐ Psychiatric Problems	☐ Ulcers
☐ Asthma	☐ Fainting	☐ High Blood Pressure	☐ Respiratory Problems	☐ Venereal Disease (STD)
☐ Blood Disease	☐ Glaucoma	☐ HIV / AIDS	☐ Rheumatic Fever	☐ Other_____
☐ Cancer	☐ Headaches/Migraines	☐ Kidney Disease	☐ Rheumatism	_____
☐ Diabetes Type:_____	☐ Head Injuries	☐ Liver Disease	☐ Sinus Problems	_____

MEDICATIONS: Are you taking any of the following? (Please check ALL that apply.)

☐ Acetaminophen	☐ Oral Diabetes Medication
☐ Antibiotics	☐ Steroids
☐ Antidepressants	☐ Thyroid Medication
☐ Antihistamines	☐ Tranquilizers
☐ Aspirin	☐ Vitamins/Supplements
☐ Asthma Inhaler	☐ Other_____
☐ Blood Pressure Medication	_____
☐ Blood Thinner _____	_____
☐ Heart Medication _____	_____
☐ Insulin	_____
☐ Nitroglycerine	

ALLERGIES: Are you allergic to any of the following? (Please check ALL that apply.)

☐ Aspirin	☐ Seasonal allergies
☐ Barbiturates (sleeping pills)	☐ Sulfa Drugs
☐ Codeine	☐ Tetracycline
☐ Erythromycin	☐ Other_____
☐ Food allergies	_____
☐ Iodine	_____
☐ Keflex	_____
☐ Local Anesthetics	_____
☐ Latex	_____
☐ Metals	_____
☐ Penicillin	

FOR WOMEN:

Are you Pregnant? ☐ No ☐ Yes Estimated due date _____/_____/_____

Obstetrician's Name_____

Are you nursing? ☐ No ☐ Yes

Are you taking birth control pills? ☐ No ☐ Yes*

*Please note: taking antibiotics can make birth control ineffective

EMERGENCY CONTACT:

Name: _____

Phone:_____

Relationship:_____

AUTHORIZATION: I affirm that the information I have given on this form is true and correct to the best of my knowledge. I understand that it is my responsibility to inform this office of any changes in my medical status.

CONSENT FOR TREATMENT: I hereby authorize the performance of dental services upon the above-named patient. I also authorize and request the administration of any anesthetics and x-rays as may be deemed necessary to enable complete diagnosis and treatment as advisable by the doctor.

_____ _____

Signature of Patient or Responsible Party Date

Please complete the following acknowledgement. NOTE: Your copy of the "Notice of Privacy Practices" is found as the last sheet on this clipboard.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You may Refuse to Sign This Acknowledgement *

I □ have □ have not received a copy of this office's Notice of Privacy Practices.

_____ _____

Signature of Patient or Responsible Party Date

FOR OFFICE USE ONLY

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

☐ Individual refused to sign

☐ An emergency situation prevented us from obtaining acknowledgement

☐ Communications barriers prohibited obtaining the acknowledgement

☐ Other_____

TLC DENTAL CARE

CYNTHIA A. GREGORY, DMD
7520 W. Washington Avenue, Suite 120
Las Vegas, Nevada 89128
702-363-1590

ASSIGNMENT OF BENEFITS AGREEMENT

Our practice will accept an assignment of benefits from your insurance company with the conditions listed below. It is important to understand, though, that the agreement regarding your dental benefits is between you, your employer, and your insurance company. The obligation you have with our practice is to pay for all treatment and services we provide you, regardless of the amount that may or may not be reimbursed by your insurance company. The following provisions identify our policies governing insurance claims.

- Although we are willing to complete insurance information forms and submit a claim on your behalf, we DO NOT accept responsibility for the outcome of the transaction. Completing insurance forms is a courtesy we extend to you in an effort to save you time and to facilitate payment to our practice from your insurance company. By having our practice process your insurance forms, it is important that you understand that this does not eliminate your financial obligation for your treatment.
- We require you to sign this agreement and/or any other necessary assignment documents that may be required by your insurance company. This instructs your insurance company to make payment directly to our practice.
- We require you to pay the **estimated** copayment, which is the amount not covered by your insurance company, at the time we provide service to you. This copayment is an **estimate only** of the applicable charges and may be found to be insufficient after review by your insurance company.
- Insurance payments are ordinarily received within 30-60 days from the time of billing. If your insurance company has not made payment to our practice within 60 days, we will ask you to pay the entire balance at that time. You will be responsible for seeking reimbursement from your insurance company. If no effort has been made by you to resolve the outstanding balance with this practice after 90 days, your account will be placed with a collection agency. You will be financially responsible for the entire balance, including any late fees, collection fees, attorneys' fees and court costs.
- Our practice DOES NOT guarantee that your insurance company will pay for treatment you receive from our practice. We perform routine insurance billing procedures upon verification of coverage. However, if your claim is denied, you will be responsible for paying the full amount at that time.
- Our practice will not enter into a dispute with your insurance company over any claim, although we will provide necessary documentation your insurance company requests to sort out any confusion or questions that may arise. We will cooperate fully with the regulations and requests of your insurance company. It is ultimately your responsibility to resolve any type of dispute over payments made or not made by your insurance company to our practice.

FINANCIAL AGREEMENT

This agreement is to inform you of your financial obligations to our practice. We are committed to providing you with the most comprehensive dental care using only the highest quality materials and technology available in the market today. We are also committed to providing you with up-to-date information and educational tools so that you may fully participate in maintaining optimum oral health. This financial agreement is intended to facilitate our ability to provide excellent service to you while minimizing our administrative costs.

All charges you incur are your responsibility. Your payment for treatment is due at the time treatment is provided. Our practice accepts cash, personal checks, Mastercard, Visa, American Express and Discover Card. Third party, extended payment financing is available upon request and approval.

Returned checks are subject to a $25.00 returned check fee. Accounts with balances older than 90 days will be placed with a collection agency. You will be financially responsible for the entire balance, including any late fees, collection fees, attorneys' fees and court costs.

Additionally, our practice will reserve the right to charge for appointments that you do not keep and for appointments that you do not cancel with 24 – hours notice.

Please do not hesitate to ask if you have any questions regarding this financial agreement. We are committed to providing you with the ultimate experience in dental care.

I HAVE READ AND ACCEPT THE TERMS AND CONDITIONS OF THIS ASSIGNMENT OF BENEFITS AND FINANCIAL. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL BENEFITS DIRECTLY TO THE PRACTICE. FURTHERMORE, I UNDERSTAND THAT I AM ULTIMATELY RESPONSIBLE FOR ANY AND ALL BALANCES ON MY ACCOUNT REGARDLESS OF WHETHER OR NOT I HAVE INSURANCE BENEFITS.

_____
Print Name of Patient or Responsible Party

_____ _____
Signature of Patient or Responsible Party Date