

## 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	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Minor (please fill out Responsible Party section)
CELL PHONE	OTHER PHONE	Best phone number to reach you for communication about your dental appointments <input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Other
HOME PHONE	WORK PHONE	EMAIL ADDRESS
OCCUPATION	EMPLOYER NAME & ADDRESS	

RESPONSIBLE PARTY	SOCIAL SECURITY # (used to verify Insurance)	DATE OF BIRTH
ADDRESS <input type="checkbox"/> 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: _____
_____

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

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.)

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

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

- |  |   |
|--|---|
| <input type="checkbox"/> Acetaminophen             | <input type="checkbox"/> Oral Diabetes Medication |
| <input type="checkbox"/> Antibiotics               | <input type="checkbox"/> Steroids                 |
| <input type="checkbox"/> Antidepressants           | <input type="checkbox"/> Thyroid Medication       |
| <input type="checkbox"/> Antihistamines            | <input type="checkbox"/> Tranquilizers            |
| <input type="checkbox"/> Aspirin                   | <input type="checkbox"/> Vitamins/Supplements     |
| <input type="checkbox"/> Asthma Inhaler            | <input type="checkbox"/> Other _____              |
| <input type="checkbox"/> Blood Pressure Medication | _____   |
| <input type="checkbox"/> Blood Thinner _____       | _____   |
| <input type="checkbox"/> Heart Medication _____    | _____   |
| <input type="checkbox"/> Insulin                   | _____   |
| <input type="checkbox"/> Nitroglycerine            | _____   |

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

- |  |   |
|--|---|
| <input type="checkbox"/> Aspirin                       | <input type="checkbox"/> Seasonal allergies |
| <input type="checkbox"/> Barbiturates (sleeping pills) | <input type="checkbox"/> Sulfa Drugs        |
| <input type="checkbox"/> Codeine                       | <input type="checkbox"/> Tetracycline       |
| <input type="checkbox"/> Erythromycin                  | <input type="checkbox"/> Other _____        |
| <input type="checkbox"/> Food allergies                | _____                                       |
| <input type="checkbox"/> Iodine                        | _____                                       |
| <input type="checkbox"/> Keflex                        | _____                                       |
| <input type="checkbox"/> Local Anesthetics             | _____                                       |
| <input type="checkbox"/> Latex                         | _____                                       |
| <input type="checkbox"/> Metals                        | _____                                       |
| <input type="checkbox"/> 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:**

- |   |   |
|---|---|
| <input type="checkbox"/> Individual refused to sign                                       | <input type="checkbox"/> An emergency situation prevented us from obtaining acknowledgement |
| <input type="checkbox"/> Communications barriers prohibited obtaining the acknowledgement | <input type="checkbox"/> 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