

# PERFECT 32 DENTAL CARE

2810 W. Charleston Blvd, Ste. F56  
Las Vegas, NV 89102  
Tel. (702) 486-5107 Fax (702) 486-6254

## PAYMENTS AND COPAYS ARE DUE BEFORE SERVICES ARE RENDERED.

Thank you for choosing Perfect 32 Dental Care for your dental needs. We promise to do our best to provide you with the finest care available. If you have any questions please do not hesitate to call us.

Today's Date: \_\_\_\_\_

### PATIENT INFORMATION

Name: Last: \_\_\_\_\_ First: \_\_\_\_\_ Middle: \_\_\_\_\_ DOB: \_\_\_\_\_  
Gender:  Male  Female Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Marital Status:  Single  Married  Divorced  Widowed  
Home Phone # \_\_\_\_\_ Work # \_\_\_\_\_ Other # \_\_\_\_\_ Cell # \_\_\_\_\_  
E-mail Address: \_\_\_\_\_ Is it okay to text and/or E-mail you?  Yes  No Initials \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_ Work # \_\_\_\_\_  
Spouse or Parent's Name: \_\_\_\_\_ Employer: \_\_\_\_\_ Work # \_\_\_\_\_  
Have you or any member of your family been a patient at this office before:  Yes  No  
If yes, please give us their name(s): \_\_\_\_\_  
Who may we thank for recommending our office to you? \_\_\_\_\_  
Otherwise, how did you learn about our practice?  Insurance  Internet  Other: \_\_\_\_\_

### Account Responsible Party

Name of person responsible for Account: Last: \_\_\_\_\_ First: \_\_\_\_\_ Middle: \_\_\_\_\_  
Relationship to patient: \_\_\_\_\_ DOB: \_\_\_\_\_ Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Home Phone # \_\_\_\_\_ Work # \_\_\_\_\_ Other # \_\_\_\_\_ Cell # \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_ Work # \_\_\_\_\_

### Primary Dental Insurance

Insured's Name: \_\_\_\_\_ / Phone #: \_\_\_\_\_ Employer: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Group or Policy # \_\_\_\_\_ Union/Group Name: \_\_\_\_\_ Local # \_\_\_\_\_

# DENTAL HISTORY

**Patient Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

What is the primary reason for your dental visit today? \_\_\_\_\_

Are you aware of any dental problems? If so, please explain: \_\_\_\_\_

Your last complete exam: \_\_\_\_\_ Your last complete x-rays: \_\_\_\_\_ Your last dental cleaning: \_\_\_\_\_

Was there any dental treatment your last dentist recommend for you? If so, please describe: \_\_\_\_\_

If your dental treatment was not completed, what prevented you from receiving it?  Time  Cost  Fear  Other \_\_\_\_\_

Previous dentist name: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Phone # \_\_\_\_\_

Please check any of the following problems that apply to you:

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Sensitivity (hot, cold, sweets) | <input type="checkbox"/> Bleeding, swollen or irritated gums   | <input type="checkbox"/> Make them straighter     |
| <input type="checkbox"/> Loose, tipped or shifting teeth | <input type="checkbox"/> Teeth or fillings breaking            | <input type="checkbox"/> Dry Mouth                |
| <input type="checkbox"/> Jaw Joint Pain                  | <input type="checkbox"/> Bad Breath or bad taste in your mouth | <input type="checkbox"/> Grinding/Clenching teeth |

Please indicate current/past dental treatments:

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Treatment for TMJ                                      | <input type="checkbox"/> Wear a night-guard | <input type="checkbox"/> Braces                                    |
| <input type="checkbox"/> Dentures/partial dentures, how old _____ U/L _____ U/L |   | <input type="checkbox"/> Dental implants, when _____               |
| <input type="checkbox"/> Deep Cleanings/periodontal treatment, when _____       |   | <input type="checkbox"/> Teeth extracted (adult teeth), when _____ |

If you could whiten your teeth for a cost you could afford would you do it?  Yes  No

If you could change anything about your smile it would be:

- |   |   |
|---|---|
| <input type="checkbox"/> Make them brighter       | <input type="checkbox"/> Make them straighter                               |
| <input type="checkbox"/> Close spaces             | <input type="checkbox"/> Replace metal fillings with tooth colored fillings |
| <input type="checkbox"/> Repair chipped teeth     | <input type="checkbox"/> Replace missing teeth                              |
| <input type="checkbox"/> Alternative to a denture | <input type="checkbox"/> Replace old crowns that do not match               |
| <input type="checkbox"/> Get a smile makeover     |   |

## Medical History

**Please check any of the following that APPLIES TO THE PATIENT:**

- |   |  |  |   |   |
|---|--|--|---|---|
| <input type="checkbox"/> Aids/HIV +               | <input type="checkbox"/> Anemia              | <input type="checkbox"/> Arthritis             | <input type="checkbox"/> Artificial joint               | <input type="checkbox"/> Artificial heart valve |
| <input type="checkbox"/> Seasonal Allergies       | <input type="checkbox"/> Asthma              | <input type="checkbox"/> Blood disease         | <input type="checkbox"/> Bruise easily                  | <input type="checkbox"/> Cancer                 |
| <input type="checkbox"/> Chemotherapy             | <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Dizziness             | <input type="checkbox"/> Drug addiction                 | <input type="checkbox"/> Emphysema              |
| <input type="checkbox"/> Excessive bleeding       | <input type="checkbox"/> Fainting            | <input type="checkbox"/> Glaucoma              | <input type="checkbox"/> Heart Condition                | <input type="checkbox"/> Heart murmur           |
| <input type="checkbox"/> Hepatitis A/B/C          | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Low blood pressure    | <input type="checkbox"/> Jaundice                       | <input type="checkbox"/> Kidney disease         |
| <input type="checkbox"/> Mitral valve prolapsed   | <input type="checkbox"/> Anxiety/Depression  | <input type="checkbox"/> Pacemaker             | <input type="checkbox"/> Osteoporosis/penia             | <input type="checkbox"/> Radiation              |
| <input type="checkbox"/> Respiratory illness      | <input type="checkbox"/> Rheumatic fever     | <input type="checkbox"/> Rheumatism            | <input type="checkbox"/> Seizures                       | <input type="checkbox"/> Stomach problems       |
| <input type="checkbox"/> Stroke                   | <input type="checkbox"/> Thyroid disease     | <input type="checkbox"/> Currently pregnant?   | <input type="checkbox"/> Liver disease                  | <input type="checkbox"/> Latex allergy          |
| <input type="checkbox"/> Allergies to antibiotics | <input type="checkbox"/> Tuberculosis        | <input type="checkbox"/> Phen-fen (diet pills) | <input type="checkbox"/> Other medical conditions _____ |   |

Do you smoke or use chewing tobacco?  Yes  No How much? \_\_\_\_\_ How long? \_\_\_\_\_

Do you use any recreational drugs?  Yes  No Which drugs? \_\_\_\_\_

What medical conditions are you currently being treated for? \_\_\_\_\_

Physicians name: \_\_\_\_\_ Phone # \_\_\_\_\_ Fax # \_\_\_\_\_

Please list any medications you are currently taking: \_\_\_\_\_

Please list any medications you are allergic to or have bad reactions to: \_\_\_\_\_

*To the best of my knowledge, I have answered every question completely and accurately. It is my responsibility to inform Perfect 32 Dental Care of any changes in my health and or medications.*

**Patient/Guardian signature:** \_\_\_\_\_ **Print Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

## HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, healthcare operations;
- The practice reserves the right to change the privacy policy as allowed by law;
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions;
- The patient has the right to revoke this consent in writing at any time and all full disclosure will then cease;
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? YES NO

If so, who is your cell phone provider? \_\_\_\_\_

May we leave a message on your answering machine at home or on your cell phone? YES NO

May we discuss your medical condition with any member of your family? YES NO

If YES, please name the members allowed:

\_\_\_\_\_  
\_\_\_\_\_

This consent was signed by: \_\_\_\_\_  
(PRINT NAME PLEASE)

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# Payment Policy

Payment at the time of services is expected. For your convenience, we take Care Credit, Credit or Debit cards. Our office will be happy to submit claims to your insurance company. A service charge of 1-1/2% per month will be added to all balances 60 days and older. The annual rate of the service charges is 18%. I understand that Perfect 32 Dental Care will make every effort to collect from my insurance company. I hereby authorize Perfect 32 Dental Care to furnish information to insurance carriers concerning my treatment and I hereby assign to the dentist all payments for dental services rendered covered by insurance for services rendered to me or my dependents. I also acknowledge and understand that if the account is turned over to an attorney for collection, I hereby agree to pay thirty percent (30%) attorney or collection agency fees on the unpaid balance. Please understand that our appointment times are scheduled to allow us to take care of each individual patient's needs during the patient's visit. Since appointment times at Perfect 32 Dental Care are in high demand, we value advance notice from our patients who are unable to keep their scheduled appointments. In an effort to decrease unnecessary costs related to staffing and supplies and in order to contain our costs and continue to provide you with affordable fine dentistry for your entire family, we maintain a No-Show/Cancellation Policy for all of our patients. To promote efficient access to our clinic, we require that any appointment that is no longer needed or is unable to be kept, must be cancelled at least 24 hours in advance of the appointment.

# Cancellation Policy

Cancellations must be made during normal business hours on workdays at least one full business day before the scheduled appointment. Cancellations must be done over the phone by speaking directly to one of our dental professionals. Patients will not be charged if cancellation is made 24 business hours before their appointment. Since we certainly understand that illness or other problems can occur (sometimes without any warning), we will not charge you for your first missed or cancelled appointment. In the event a second appointment is missed or cancelled with less than 24 hours notice, or no notice, a \$25 charge will be billed. If a third no-show or same day cancellation occurs, we reserve the right to terminate the doctor-patient relationship as well as another \$25 charge. This policy is in effect for all appointments at our office. Please acknowledge that you have had the opportunity to review this policy by signing below. The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself, spouse, or dependents including the assignment of benefits payable to PERFECT 32 DENTAL CARE. I further agree and acknowledge that my signature on this document authorizes my dentist to submit for myself, spouse, or dependents all insurance claim forms necessary for submission and that I will be bound by this signature as though the undersigned had personally signed the particular claim form. Past due balances are subject to a late payment of 1-1/2% per month (18% annual).

Relationship to Patient: \_\_\_\_\_  
Signature: \_\_\_\_\_