

Patient or Responsible Party Information

The following is for (circle one) patient person responsible for payment

Name _____ (circle one) Male Female (circle one) married single child other

Social Security # _____ Birth Date _____

Phone: home _____ work _____ Ext _____ cell _____

Address: _____

Lone Mountain Family Dentistry
461 Hot Springs Rd.
Carson City, NV 89706
(775) 883-1092

Employment Information

The following is for (circle one) patient person responsible for payment

Employer Name _____ Occupation _____

Employer Address _____

Insurance Information

Primary

Name of Insured _____ Is insured a patient yes no Insured's Birth Date _____ SS# _____

Patient's relationship to insured _____ self spouse child other _____

Insured's Address _____

Insured's Employer Name _____

Employers Address _____

Insurance Plan Name and Address _____ group # _____

Secondary

Name of Insured _____ Is insured a patient yes no Insured's Birth Date _____ SS# _____

Patient's relationship to insured _____ self spouse child other _____

Insured's Address _____

Insured's Employer Name _____

Employers Address _____

Insurance Plan Name and Address _____ group # _____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid at the time services are performed.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 30 days.

I understand that the fee estimate for dental care can only be extended for a period of six months from the date of the estimate.

In consideration for the professional services rendered to me, I agree to pay at the time said services are rendered, or within five (5) days of billing if credit shall be extended.

Signature on File: - I authorize: a copy of this form may be used in place of the original, use of this form on all of my insurance submissions, release of information to all of my insurance carriers, for doctor to obtain payment from insurance carriers, and direct payment from insurance carriers to doctor. I understand that I am responsible for the entire amount of my bill.

_____ Date _____ Relationship to Patient: _____
Print name of responsible party

_____ In case of emergency contact: Name _____
Signature of responsible party

Phone _____

Name: Last _____ First _____ Middle _____ Birthdate _____

Patient Medical History

Physician name _____ Office Phone _____ Date of last exam _____

Are you currently under the care of a physician? Yes No
 If yes, please explain? _____

Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? Yes No
 If yes, please explain? _____

Are you taking any drug(s) or medication(s) including non-prescription? Yes No
 If yes, what? _____ What dosage? _____

Are you allergic to or have had any reactions to the following? (If yes, please circle)
 Penicillin, Tetracycline, Sulfa drugs, Barbituates, Aspirin, Sedatives, Iodine, Latex rubber,
 Any metals (eg. Nickel, Mercury, etc.), Local anesthetics.
 Other (please list) _____

Do you have, or have had any of the following?

Anemia	Yes	No	Rheumatic Fever	Yes	No	Environmental allergies	Yes	No
High blood pressure	Yes	No	Swollen ankles	Yes	No	Artificial Prosthesis		
Low blood pressure	Yes	No	Frequently tired	Yes	No	(Implants/Replacements)	Yes	No
Diabetes	Yes	No	Cancer	Yes	No	Difficulty in swallowing	Yes	No
Excessive bleeding	Yes	No	Tumors or growths	Yes	No	Stomach ulcers	Yes	No
Leukemia	Yes	No	Radiation treatment	Yes	No	Sexually transmitted disease	Yes	No
Blood diseases	Yes	No	Respiratory disease	Yes	No	AIDS or HIV Infection	Yes	No
Hepatitis/Jaundice	Yes	No	Tuberculosis	Yes	No	Herpes	Yes	No
Liver disease	Yes	No	Emphysema	Yes	No	Glaucoma	Yes	No
Thyroid condition	Yes	No	Asthma/Hay fever	Yes	No	Smoke cigarettes/cigars/pipes	Yes	No
Stroke	Yes	No	Sinus trouble	Yes	No	How much? _____		
Heart condition	Yes	No	Head injuries	Yes	No	Chew tobacco	Yes	No
Cardiac Pacemaker	Yes	No	Nervous Disorders	Yes	No	How much? _____		
Heart Surgery	Yes	No	Fainting spells/Seizures	Yes	No	More than one		
Heart attack	Yes	No	Epilepsy/convulsions	Yes	No	alcoholic drink per day	Yes	No
Heart murmur	Yes	No	Mental disorders	Yes	No	Dry mouth	Yes	No
Angina	Yes	No	Kidney Disease	Yes	No	Latex	Yes	No
Mitral Valve Prolapse	Yes	No	Do you urinate frequently	Yes	No			

Have you ever taken Phen-Fen or other prescription diet medication? Yes No
 If so, what? _____ For how long? _____

Do you have any disease, condition or problem not listed that you think I should know about?
 If so, what? _____

Do you take diet pills on & off or regularly? If so, what? _____

Are you pregnant? Yes No If so, how many months? _____

Are you currently breast-feeding? Yes No

Do you have problems with your menstrual period? Yes No
 If so, what? _____

Patient Dental History

Name of former Dentist: _____

Address: _____ Phone: _____

Do you see a Dentist on a regular basis? Yes No

How long since your last Dental visit? _____

Have you ever had orthodontic treatment? Yes No

How long ago? _____

Have you ever had gum surgery? Yes No

How long ago? _____

How often do you Brush? _____ Floss? _____ Use a waterpik? _____ Use a toothpick? _____
 Proxy brush? _____ Perio Aid? _____ Other dental devices? _____

Do your gums bleed when you brush or floss? Yes No
 Do you have any swelling or lumps in your mouth? Yes No
 Do you clench or grind your teeth? Yes No
 Are you under a lot of stress? Yes No
 Do you have frequent headaches? Yes No

Have you ever experienced any of the following problems in your jaw?
 Clicking Yes No
 Pain (joint, ear or side of face) Yes No
 Difficulty in opening or closing Yes No
 Difficulty in chewing Yes No

Do you like your smile?
 If no, what would you change? _____

Are you nervous about receiving treatment? Yes No
 Are you having any discomfort at this time? Yes No
 If so describe: _____

Purpose of this appointment? _____

Terms and Conditions

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental service performed without prior financial arrangements, must be paid for at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms to assist in making collections from insurance companies and will credit such collections to the patient's accounts. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1-1/2% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 30 days from the date of the patient's examination.

In consideration of the professional services rendered to me, or at my request, by the Doctor and/or his staff, I agree to pay, therefore, the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be billed unless objected too, by me in writing, within the time for payment thereof. Additionally, I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you, or your assigns to telephone me at home or at my work to discuss matters related to this form. I certify that I have read and understand the above information to the best of my knowledge. I have answered the above questions accurately knowing that providing inaccurate information can be dangerous to my health.

Signed: _____ Date: _____

Consent for Treatment

I hereby grant authority to the dentist(s) in charge of the care of the patient whose name appears on this Health History form, to administer any treatment, or to administer such anesthetics, analgesics, sedatives and nitrous oxide sedation, and to perform such operations as may be deemed necessary or advisable in the diagnosis and treatment of this patient. I have been informed of possible complications of the procedures, anesthetics and/or drugs.

Signed: _____ Date: _____

Authorization must be signed by the patient, or by the nearest relative in the case of a minor or when the patient is physically or mentally incompetent.

Relationship to the patient: _____

**Lone Mountain Family Dentistry
Kevin Peterson, DDS**

**CONSENT FOR USE AND DISCLOSURE
OF HEALTH INFORMATION**

PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone _____ Social Security # _____

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, including sending xrays via unencrypted email to a specialist if a referral is necessary.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign the 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.

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.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice at any time by contacting:

Kristen Brodie
Phone (775)883-1092
461 Hot Springs Road Carson City, NV 89706

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.

PRINT

I, _____, have had full opportunity to read and consider the contents of this Consent for 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.
INCLUDE COMPLETED CONSENT IN THE PATIENT'S CHART**

**Lone Mountain Family Dentistry
461 Hot Springs Road
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Health Information Disclosure to Family and Friends Authorization

I authorize the disclosure of my health information to a family member, friend or other person to the extent necessary to help with my healthcare or with payment for my healthcare. I understand that I may revoke this authorization at any time in writing. My revocation will not affect any use or disclosures permitted by my authorization while it was in effect.

Person(s) I authorize:

_____	Relationship

Patient/Guardian

Signature: _____ **Date:** _____

Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in the Notice of Privacy Practices.