Patient or Responsible Party Information

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

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: ______________________________

____

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 ______________

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 during 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