



1525 W. Warm Springs Road
Suite 100
Henderson, Nevada 89014
702.454.0818
Fax 702.454.3716

2520 Anthem Village Dr.
Suite 100
Henderson, Nevada 89052
702.454.7704
Fax 702.454.0200

Todd W. Newton, D.D.S.
Corry L. Timpson, D.D.S.
Robert W. Nisson, D.D.S.

VIBRANT DENTAL

MEDICAL HISTORY

Patient's Name _____ Date _____

Medical Physician _____ Physician's Phone () _____

- | | YES | NO |
|--|--------------------------|--------------------------|
| 1. Are you having pain or discomfort at this time? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Do you feel very nervous about having dentistry treatments? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you ever had a bad experience in the dentist's office? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you been a patient in the hospital during the last two years? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you been under the care of a medical doctor during the past two years? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you taken any medicine or drugs during the past two years? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Are you allergic or sensitive to latex? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Have you ever taken Fosamax or any osteoporosis medication? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Are you allergic to (i.e. itching, rash, swelling of hands, feet or eyes) or made sick by penicillin, Aspirin, codeine, or any drugs or medication? | <input type="checkbox"/> | <input type="checkbox"/> |

Please check any of the following which you have had or have at present.

- | | | |
|---|--|--|
| <input type="checkbox"/> Heart Failure | <input type="checkbox"/> Emphysema | <input type="checkbox"/> HIV/Aids |
| <input type="checkbox"/> Heart Disease or Attack | <input type="checkbox"/> Chronic Bronchitis | <input type="checkbox"/> Hepatitis A- Infectious |
| <input type="checkbox"/> Angina Pectoris | <input type="checkbox"/> Cough | <input type="checkbox"/> Hepatitis B- Serum |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Tuberculosis (TB) | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Asthma | <input type="checkbox"/> Yellow Jaundice |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Blood Transfusion |
| <input type="checkbox"/> Congenital Heart Lesions | <input type="checkbox"/> Sinus Trouble | <input type="checkbox"/> Drug/ Alcohol Abuse |
| <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Allergies/ Hives | <input type="checkbox"/> Hemophilia |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Cold Sores |
| <input type="checkbox"/> Heart Pacemaker | <input type="checkbox"/> X-Ray/ Cobalt Treatment | <input type="checkbox"/> Genital Herpes |
| <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Chemotherapy (Cancer) | <input type="checkbox"/> Epilepsy/ Seizures |
| <input type="checkbox"/> Artificial Joint | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Fainting/ Dizzy Spells |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Rheumatism | <input type="checkbox"/> Nervousness |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Cortisone Medicine | <input type="checkbox"/> Psychiatric Treatment |
| <input type="checkbox"/> Kidney Trouble | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Ulcers | <input type="checkbox"/> Pain in Jaw Joints | <input type="checkbox"/> Bruise Easily |
| <input type="checkbox"/> Leukemia | <input type="checkbox"/> Syphilis | <input type="checkbox"/> Gonorrhoea |

- | | YES | NO |
|---|--------------------------|--------------------------|
| 10. Have you ever had any excessive bleeding requiring special treatment..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, or shortness of breath, or because you are very tired?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Do your ankles swell during the day?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Do you use more than 2 pillows to sleep?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Have you lost or gained more than 10 pounds in the past year?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Do you ever wake up from sleep short of breath?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Are you on a special diet?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Has your medical doctor ever said you have cancer or tumor?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Do you have any disease, condition or problem not listed?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. For Women Only: Are you pregnant now?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you practicing birth control?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you anticipate becoming pregnant?..... | <input type="checkbox"/> | <input type="checkbox"/> |

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health, or if my medicines change, I will inform the doctor of dentistry at the next appointment without fail.

Current Medical Problems

Current Medications for Problem

Patient's Signature _____ Doctor's Signature _____ Date _____

Patient's Signature _____ Doctor's Signature _____ Date _____



1525 W. Warm Springs Road
Suite 100
Henderson, Nevada 89014
702.454.0818
Fax 702.454.3716

2520 Anthem Village Dr.
Suite 100
Henderson, Nevada 89052
702.454.7704
Fax 702.454.0200

Todd W. Newton, D.D.S.
Corry L. Timpson, D.D.S.
Robert W. Nisson, D.D.S.

ViBRANT DENTAL

PERSONAL INFORMATION

PATIENT NAME _____ DATE OF BIRTH _____

SOC. SEC # _____ MALE _____ FEMALE _____

ADDRESS _____ APT. _____

(CITY) (STATE) (ZIP CODE)

HOME # _____ CELL # _____ EMAIL _____

EMPLOYER _____ POSITION _____ PHONE # _____

PARENT/SPOUSE NAME _____ PHONE # _____

MEDICAL PHYSICIAN OF ABOVE PATIENT _____ PHONE # _____

PREVIOUS DENTIST _____

(NAME) (PHONE)

ADDRESS _____

** EMERGENCY CONTACT _____ PHONE # _____

(NEAREST RELATIVE NOT LIVING WITH YOU)

RESPONSIBLE PARTY

WHO IS RESPONSIBLE FOR THIS ACCOUNT? _____

RELATIONSHIP TO PATIENT _____

DATE OF BIRTH _____ SOC. SEC# _____ MALE _____ FEMALE _____

DRIVERS LICENSE # _____

(STATE) (EXPIRATION)

HOME ADDRESS _____

(CITY) (STATE) (ZIP CODE)

HOME PHONE # _____ CELL PHONE # _____

EMPLOYER _____ POSITION _____ PHONE # _____

EMPLOYER ADDRESS _____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____



1525 W. Warm Springs Road
 Suite 100
 Henderson, Nevada 89014
 702.454.0818
 Fax 702.454.3716

2520 Anthem Village Dr.
 Suite 100
 Henderson, Nevada 89052
 702.454.7704
 Fax 702.454.0200

Todd W. Newton, D.D.S.
 Corry L. Timpson, D.D.S.
 Robert W. Nisson, D.D.S.

VIBRANT DENTAL

INSURANCE INFORMATION

PRIMARY INSURANCE

Who is the insurance holder? _____

Relationship to patient _____ Birth Date _____ Soc. Sec. # _____

Address (if different from patient's) _____ Phone _____

City _____ State _____ Zip _____

Subscriber employed by _____ Occupation _____

Business Address _____ Business Phone _____

Insurance Company _____

Phone # _____ Group # _____ Subscriber # _____

SECONDARY INSURANCE

Who is the insurance holder? _____

Relationship to patient _____ Birth Date _____ Soc. Sec. # _____

Address (if different from patient's) _____ Phone _____

City _____ State _____ Zip _____

Subscriber employed by _____ Occupation _____

Business Address _____ Business Phone _____

Insurance Company _____

Phone # _____ Group # _____ Subscriber # _____

ASSIGNMENT OF BENEFITS: I hereby authorize and request my insurance company to pay directly to Warm Springs Dental the amount due on my claim for services rendered to me or my dependent. I further agree that should the amount be insufficient to cover the entire dental expense, I will be responsible for payment of the difference; and if the nature of the liability be such that it is not covered by the policy, I will be responsible to Warm Springs Dental for payment of the entire bill.

Signed _____ Date _____



1525 W. Warm Springs Road
Suite 100
Henderson, Nevada 89014
702.454.0818
Fax 702.454.3716

2520 Anthem Village Dr.
Suite 100
Henderson, Nevada 89052
702.454.7704
Fax 702.454.0200

Todd W. Newton, D.D.S.
Corry L. Timpson, D.D.S.
Robert W. Nisson, D.D.S.

VIBRANT DENTAL

TO OUR VALUED PATIENT

Thank you for choosing us as your dental care provider. We are committed to providing you with the best care possible. In order to achieve this goal, we need your assistance and your understanding of our financial policies. If you have any questions or concerns regarding these policies, please feel free to ask any of our staff. If you would like a photocopy of this outline, please ask.

Payment for services are due at the time services are rendered. We accept cash, checks, Mastercard, Visa, Discover or American Express. We will submit an insurance claim on your behalf if you show proof of coverage. If your insurance company/ coverage changes please notify us immediately.

Please understand the following:

- Your insurance policy is a contract between you, your employer, and the insurance company. We are not a party to that contract. Our relationship is with you, the patient.
- Although we routinely try to secure payment from your insurance company by acting as the go-between, all charges are your responsibility whether the insurance company pays or not. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under your dental insurance. Fees for these services, along with unpaid deductibles and co-payments are due at the time of treatment.
- You are responsible for knowing your insurance benefits. Is preauthorization required for any treatment exceeding \$500.00? Is your insurance a PPO or is it an open plan? If we can be of assistance, please let us know.
- If your insurance company does not pay in full within 30 days, we ask you to contact your insurance company to check status. If after 45 days they do not pay the balance is due. We expect prompt payment from you within 10 days of statement received for any balance due after insurance pays.
- Any patient who fails to show up for their appointment and does not call to reschedule at least 48 hours in advance, may be charged \$50.00.
- Any balance due on account over 90 days is subject to an 18% service charge.
- Returned checks are subject to a \$25.00 returned check fee.
- In the event your account is sent to collection agency, you will be responsible for any collection fee, legal fees or court costs.
- You agree, in order to service your account or to collect any amounts you may owe, we may contact you by telephone at any number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or e-mails, using any email address you provide to us. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automated service, as applicable.

Our practice is committed to providing the best treatment for our patients. We encourage you to notify us of any changes to your health status or any of the above information.

Patient's Name (Please Print) _____

Patient's Signature _____ Date _____



1525 W. Warm Springs Road
 Suite 100
 Henderson, Nevada 89014
 702.454.0818
 Fax 702.454.3716

2520 Anthem Village Dr.
 Suite 100
 Henderson, Nevada 89052
 702.454.7704
 Fax 702.454.0200

Todd W. Newton, D.D.S.
 Corry L. Timpson, D.D.S.
 Robert W. Nisson, D.D.S.

ViBRANT DENTA

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information (PHI). I understand that PHI can and will be used as outlined in the *Notice of Privacy Practices* that I have read.

I understand that this practice has the right to change its *Notice of Privacy Practices* from time to time and that I may obtain a current copy at any time.

I understand that I may request in writing that this practice restricts how my PHI is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree with my restrictions, but if you do agree, then you are bound to abide by such restrictions.

Patient's Name _____

Relationship to Patient _____

Signature _____ Date _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgment of this *Notice of Privacy Practices Acknowledgment*, but was unable to do so as documented below:

Date	Initials	Reasons