ViBRANT DENTAL

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.

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 REPONSIBLE 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 _____POSTION_____ PHONE #_____

EMPLOYER ADDRESS _____

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

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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 _____

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MEDICAL HISTORY

Patient's Name _____ Date _____

Medical Physician _____ Physician's Phone ( ) _____

		YES	NO
1.	Are you having pain or discomfort at this time?	❑	❑
2.	Do you feel very nervous about having dentistry treatments?	❑	❑
3.	Have you ever had a bad experience in the dentist's office?	❑	❑
4.	Have you been a patient in the hospital during the last two years?	❑	❑
5.	Have you been under the care of a medical doctor during the past two years?	❑	❑
6.	Have you taken any medicine or drugs during the past two years?	❑	❑
7.	Are you allergic or sensitive to latex?	❑	❑
8.	Have you ever taken Fosamax or any osteoporosis medication?	❑	❑
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?	❑	❑

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

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

		YES	NO
10.	Have you ever had any excessive bleeding requiring special treatment	❑	❑
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?	❑	❑
12.	Do your ankles swell during the day?	❑	❑
13.	Do you use more than 2 pillows to sleep?	❑	❑
14.	Have you lost or gained more than 10 pounds in the past year?	❑	❑
15.	Do you ever wake up from sleep short of breath?	❑	❑
16.	Are you on a special diet?	❑	❑
17.	Has your medical doctor ever said you have cancer or tumor?	❑	❑
18.	Do you have any disease, condition or problem not listed?	❑	❑
19.	**For Women Only:** Are you pregnant now?	❑	❑
	Are you practicing birth control?	❑	❑
	Do you anticipate becoming pregnant?	❑	❑

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 _____

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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 you 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 so 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 90days 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_____

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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