welcome

SummerHills Dental

Age _____ Date _____

Patient's Name _____ _____ Date of Birth _____ ☐ Male ☐ Female
Last First

If Child: Parent's Name _____

How do you wish to be addressed _____

Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Minor ☐

Residence Street _____

City _____ State _____ Zip _____

Business Address _____

Telephone: Res._____ Bus. _____

Fax _____Cell Phone# _____

eMail _____

Patient/Parent Employed By _____

Present Position _____

How Long Held _____

Spouse/Parent Name _____

Spouse Employed By _____

Present Position _____

How Long Held _____

Who is Responsible for this account _____

Drivers License No. _____

Method of Payment: Insurance ☐ Cash ☐ Credit Card ☐

Purpose of Call _____

Other Family Member in this Practice _____

_____

Whom may we thank for this referral _____

Patient/Parent Social Security No. _____

Spouse/Parent Social Security No. _____

Someone to notify in case of emergency not living with you:

_____

DENTAL INSURANCE 1ST COVERAGE

Employee Name _____ Date of Birth _____
Employer Name _____ Yrs. _____
Name of Insurance Co. _____
Address _____

_____

Telephone _____
Program or policy # _____
Social Security No. _____
Union Local or Group _____

DENTAL INSURANCE 2ND COVERAGE

Employee Name _____ Date of Birth _____
Employer Name _____ Yrs. _____
Name of Insurance Co. _____
Address _____

_____

Telephone _____
Program or policy # _____
Social Security No. _____
Union Local or Group _____

CONSENT:

I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.

I consent to the dentist's use and disclosure of the records (or any child's records) to carry out treatment, to obtain payment, and for those activities and health care operations that are related to treatment or payment.

I consent to the disclosure of my records (or my child's record) to the following persons who are involved in my care(or my child's care) or payment for that care.

_____

My consent to disclosure of records shall be effective until I revoke it in writing.

I authorize payment directly to the dentist or dental group of insurance benefits otherwise payable to me. I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services, and that I am financially responsible for payment in full of all accounts. By signing this statement, I revoke all the previous agreements to the contrary and agree to be responsible for payment of services not paid, by my dental care payor.

I attest the accuracy of the information on this page.

PATIENT OR GUARDIAN'S SIGNATURE

_____

DATE _____

REGISTRATION

welcome

SummerHills Dental

Patient's Name _____
Last First Initial Date of Birth

CIRCLE THE APPROPRIATE ANSWER: IF YOU DON'T KNOW THE CORRECT ANSWER, PLEASE WRITE "DON'T KNOW" ON THE LINE AFTER THE QUESTION.

1. Physician's Name _____
   Address _____
   _____ Tel - (_____)_____
2. Are you under a physician's care? . . . . . YES NO
   Since when _____ Why _____
3. When was your last complete physical exam? _____
4. Are you taking any medication or substances? . . . . . YES NO
   (If yes, please list medications in comments section to the right)
5. Do you routinely take health related substances?(Vitamins, herbal supplements, natural products).YES NO
6. Are you allergic to any medications or substances? (please list) . . . . . YES NO
7. Do you have any other allergies or hives? . . . . . YES NO
8. Do you have any problems with penicillin, antibiotics, anesthetic or other medications? . . YES NO
9. Are you sensitive to any metals or latex? . . . . . YES NO
10. Are you pregnant or suspect you may be? . . . . . YES NO
11. Do you use any birth control medications? . . . . . YES NO
12. Have you never been treated for or been told you might have heart disease? . . . . . YES NO
13. Do you have a pacemaker, an artificial heart valve implant, or been diagnosed with mitral valve prolapse? . . . . . YES NO
14. Have you ever had rheumatic fever? . . . . . YES NO
15. Are you aware of any heart murmurs? . . . . . YES NO
16. Do you have high or low blood pressure? (please circle) . . . . . YES NO
17. Have you ever had a serious illness or major surgery?. . . . . YES NO
    If so, please explain _____
18. Have you EVER had radiation, chemo treatment for tumor growth or other condition? . . YES NO
19. Have you EVER taken Fosamax, Zometa, Aredia or any other oral or intravenous treatment (bisphosphonates) for bone tumors, excessive calcium in your blood, or osteoporosis? . . . . YES NO
20. Do you have inflammatory diseases, such as arthritis or rheumatism? . . . . . YES NO
21. Do you have any artificial joints/prosthesis? . . . . . YES NO
22. Do you have any blood disorder, such as anemia, leukemia, etc?. . . . . YES NO
23. Have you ever bled excessively after being cut or injured? . . . . . YES NO
24. Do you have any stomach problems? . . . . . YES NO
25. Do you have any kidney problems? . . . . . YES NO
26. Do you have any liver problems? . . . . . YES NO
27. Are you diabetic? . . . . . YES NO
28. Do you have fainting or dizzy spells? . . . . . YES NO
29. Do you have asthma? . . . . . YES NO
30. Do you have epilepsy or seizure disorders? . . . . . YES NO
31. Do you or have you had venereal or any sexual transmitted disease? . . . . . YES NO
32. Have you tested HIV positive? . . . . . YES NO
33. Do you have AIDS? . . . . . YES NO
34. Have you had or do you test positive for hepatitis? . . . . . YES NO
35. Do you or have you had T.B.? . . . . . YES NO
36. Do you smoke, chew, use snuff or any other forms of tobacco? . . . . . YES NO
37. Do you regularly consume more than one or two alcoholic beverages a day? . . . . . YES NO
38. Do you habitually use controlled substances? . . . . . YES NO
39. Have you had psychiatric treatment? . . . . . YES NO
40. Have you taken any prescription drugs fenfluramine, fenfluramine combines with phentermine (fen-phen), dexfenfluramine (redux), or other weight loss products? . . . . . YES NO
41. Do you have any disease, condition, or problem not listed? If so, explain: _____
    _____
42. Is there anything else we should know about your health that we have not covered in this form?
    _____
43. Would you like to speak to the Doctor privately about any problem? . . . . . YES NO

ALLERGIES

MEDS/COMMENTS

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE
PATIENT / GUARDIAN'S SIGNATURE _____ DATE _____
DENTIST'S SIGNATURE _____ DATE _____

ANEST.

MEDICAL HISTORY

MED. ALERT

welcome

SummerHills Dental

Patient's Name _____
Last First Initial Date of Birth

Parent/Guardian's Name _____

DENTAL HISTORY - CIRCLE THE APPROPRIATE ANSWER

1. Is this our child's first visit to a dentist? . . . . . YES NO
2. If not, how long since the last visit to the dentist? _____
3. Were any x-rays taken when you child previously visited the dentist? . . . . . YES NO
4. Does your child eat between meals? . . . . . YES NO
5. Does your child eat sweets, such as candy, soda pop, chewing gum? . . . . . YES NO
6. When does your child brush his/her teeth?
   ☐ Upon arising ☐ After eating any food ☐ Right after meals ☐ Before going to bed
7. How does your child receive fluoride?
   ☐ Community water level _____ ppm ☐ Well water level _____ ppm
   ☐ Fluoride drops or tablets ☐ Fluoride rinse of gel
8. Have any cavities been noted in the past? . . . . . YES NO
9. Were any teeth (baby or permanent) removed by extraction? . . . . . YES NO
   Was it suggested that the space be maintained? . . . . . YES NO
   Was an appliance placed? . . . . . YES NO
10. Have there been many injuries to teeth such as falls, blows, chips, etc? . . . . . YES NO
    If so, describe _____
11. Has your child had any problem with dental treatment in the past? . . . . . YES NO
12. Has anyone in the family, including parents, had orthodontics? . . . . . YES NO
13. Has your child ever received a local anesthetic? . . . . . YES NO
14. Has your child ever had occlusal sealants? . . . . . YES NO
15. Does your child think there is anything wrong with his/her teeth? . . . . . YES NO

MEDICAL HISTORY

1. Does your child have a health problem? . . . . . YES NO
2. Is your child under care of physician? . . . . . YES NO
   If yes, since when and why? _____
3. Name of physician _____
4. Is your child receiving any medication? . . . . . YES NO
   What? _____
5. Is your child allergic to penicillin, antibiotics or other drugs? . . . . . YES NO
6. Is your child allergic to or sensitive to any metals or latex? . . . . . YES NO
7. Does your child have other allergies? . . . . . YES NO
8. Has your child had any serious illness? . . . . . YES NO
   When _____
9. Has your child ever had surgery? . . . . . YES NO
10. Does your child have a heart murmur? . . . . . YES NO
11. Is surgery contemplated? . . . . . YES NO
12. Does your child experience severe or prolongated bleeding? . . . . . YES NO
13. Does your child have AIDS or has he/she tested HIV positive? . . . . . YES NO
14. Has your child tested positive for hepatitis? . . . . . YES NO
15. Is your child subject to nervous disorders? . . . . . YES NO
    ☐ Fainting ☐ Seizures ☐ Dizziness ☐ Behavioral/Learning problems?
16. Does your child have frequent headaches? . . . . . YES NO
17. Has your child had a history of: (circle appropriate responses) diabetes, heart trouble, asthma, kidney infection, rheumatic fever, epilepsy, cerebral palsy, liver problems, congenital birth defects, mental retardation, eyesight problems, cancer, infections, speech impairments, hearing loss.

COMMENTS

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT / GUARDIAN'S SIGNATURE _____ DATE _____

DENTIST'S SIGNATURE _____ DATE _____

ANEST.

MED. ALERT

CHILD DENTAL/MEDICAL HISTORY

welcome

SummerHills Dental

Patient's Name _____
Last First Initial Date of Birth

1. Purpose of initial visit _____
_____
2. Are you aware of a problem? _____
_____
3. How long since your last dental visit? _____
4. What was done at that time?_____
_____
5. Previous doctor's name _____
Address: _____Tel. _____
6. When was the last time your teeth were cleaned? _____

CIRCLE THE APPROPRIATE ANSWER. IF YOU DON'T KNOW THE CORRECT ANSWER, PLEASE WRITE "DON'T KNOW" IN THE LINE AFTER THE QUESTION.

7. Have you made regular visits? . . . . . YES NO
How often. _____
8. Were dental x-rays taken? . . . . . YES NO
9. Have you lost any teeth or have any teeth been removed? . . . . . YES NO
Why? _____
10. Have they been replaced? . . . . . YES NO
11. How have they all been replaced?
    a. Fixed Bridge _____ Age _____
    b. Removable Bridge _____ Age _____
    c. Denture _____ Age _____
    d. Implant _____ Age _____
12. Are you unhappy with the replacements? . . . . . YES NO
If yes, please explain: _____
13. Would you like to know about permanent replacements? . . . . . YES NO
14. Have you ever had any problems or complications with previous dental treatment? . . . . . YES NO
If yes, please explain: _____
15. Do you clench or grind your teeth? . . . . . YES NO
16. Does your jaw click or pop? . . . . . YES NO
17. Have you experienced any pain or soreness in the muscles or your face or around your ear? . . . . . YES NO
18. Do you have frequent headaches, neck aches or shoulder aches? . . . . . YES NO
19. Does your food get caught in your teeth? . . . . . YES NO
20. Are any of your teeth sensitive to: ☐ Hot? ☐ Cold? ☐ Sweets? ☐ Pressure?
21. Do your gums bleed or hurt? . . . . . YES NO
When? _____
22. Do you experience dry mouth? . . . . . YES NO
23. How often do you brush your teeth? _____ When? _____
24. Do you use dental floss? . . . . . YES NO
How often? _____
25. Are any of your teeth loose, tipped, shifted or chipped? . . . . . YES NO
26. Are you unhappy with the appearance of your teeth? . . . . . YES NO
27. How do you feel about your teeth in general? _____
28. Do you feel your breath is offensive at times? . . . . . YES NO
29. Have you ever had gum treatment or surgery? . . . . . YES NO
What? _____
Where? _____
When? _____
30. Have you had any orthodontic work? _____
31. Have you had any unpleasant dental experiences or is there anything about dentistry that you strongly dislike? _____
32. Do you have any questions or concerns? . . . . . YES NO

COMMENTS

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT / GUARDIAN'S SIGNATURE _____ DATE _____

DENTIST'S SIGNATURE _____ DATE _____

ANEST.

MED. ALERT

DENTAL HISTORY

SummerHills Dental

Patient's Name ____
Last First Initial

I hereby authorize payment directly to ______________________________ of the dental benefits otherwise payable to me.
(DENTIST'S NAME)

____
SIGNATURE (INSURED PERSON)

____
DATE

Signature is valid for two years from the above date, unless revoked by me at an earlier date.

- -

____
ATTENDING D.D.S. NAME

is authorized to provide any insurance company(s), claim administrator(s) and consulting health care professionals, information concerning health care advice, treatment or supplies provided. This information will be used for the purpose of evaluating and administrating claims for benefits.

This authorization is valid for the term of coverage of the policy or contract, in force on this date only, or for two years, which ever is shorter.

I know I have a right to receive a copy of this authorization upon request and agree that the photographic copy of this authorization is as valid as the original.

____
PATIENT OR AUTHORIZED PERSON'S SIGNATURE DATE

SIGNATURE ON FILE

SummerHills Dental

Acknowledgement of Receipt of Notice of Privacy Practices

I, _____, have the opportunity to read and consider the contents of this this office's Notice of Privacy Practices.

Signature _____ Date _____

You may refuse to sign this acknowledgement

Consent for Use and Disclosure of Health Information

Name: _____ Telephone: _____ Social Security # _____
Address: _____

TO THE PATIENT -- 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 options.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our notice provides a description of your 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. A copy of your Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

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

Cynthia Morgan Allen, D.D.S.
2261 N. Rampart Blvd.
Las Vegas, NV 89128
(702) 363-8655

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 affe any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or continue treating you if you revoke this Consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing the Consent form, I am giving you consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care 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.

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of out Notice of Privacy Practices, but the acknowledgement could not be obtained because:

- ☐ The individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (please specify) _____