HENDERSON FAMILY DENTAL

537 South Boulder Highway, Henderson, NV 89015
P (702) 564-2526, F (702)565-7852

PATIENT INFORMATION

Date: _____ Married ☐ Single ☐

Male ☐ Female ☐ Non-Binary ☐ Prefer not to disclose ☐ Prefer to self-describe _____

Last Name: _____ First Name: _____ Middle: _____

Preferred Name: _____ DOB: _____ SS#: _____

Address: _____ City: _____ State: _____ Zip: _____

Home #: _____ Cell #: _____ Work #: _____

Email Address: _____

Name of nearest relative not living with you: _____ Phone #: _____

How did you hear about our office? ☐ Patient Name: _____ ☐ Other:_____

RESPONSIBLE PARTY INFORMATION

Last Name: _____ First Name: _____ Middle: _____

Preferred Name: _____ DOB: _____ SS#: _____

Address: _____ City: _____ State: _____ Zip: _____

Home #: _____ Cell #: _____ Work #: _____

Employer: _____ Address: _____

DENTAL INSURANCE INFORMATION

PRIMARY

Insured's Name: _____

Insured's DOB: _____

Insured's Phone #: _____

Insured's SS#: _____

Insurance Address: _____

_____

Insurance Phone #: _____

Insured's Employer: _____

SECONDARY

Insured's Name: _____

Insured's DOB: _____

Insured's Phone #: _____

Insured's SS#: _____

Insurance Address: _____

_____

Insurance Phone #: _____

Insured's Employer: _____

DENTAL INFORMATION

Do you gums bleed when you brush? ☐ YES ☐ NO

Are your teeth sensitive to heat/cold? ☐ YES ☐ NO

Are your teeth sensitive to pressure? ☐ YES ☐ NO

Do you have a fear of the dentist? ☐ YES ☐ NO

Do you grind or clench your teeth? ☐ YES ☐ NO

Have you had your teeth bleached? ☐ YES ☐ NO

How do you feel about the appearance of your teeth? Love them ☐ accept them ☐ want to change them ☐

How do you feel about the appearance of your smile? Love it ☐ accept it ☐ want to change it ☐

Date of last Examination: _____ What was done at that time? _____

Are you interested in using Nitrous Oxide (Laughing gas)? ☐ YES ☐ NO

MEDICAL HISTORY INFORMATION

Current Dental Problem(s): _____Discomfort at this time? ☐ YES ☐ NO

Have you been a patient in the hospital in the past 2 years? ☐ YES ☐ NO Under Physician Care? ☐ YES ☐ NO

Physician Name: _____ Phone #: _____

Are you taking any medications? ☐ YES ☐ NO Please list all medications: _____

_____

Are you sensitive or allergic to any medication or anesthetics? _____

_____

Indicate which of the following you have had or have at the present (Check "yes" or "no" for each)

Heart disease, attack or failure	☐ YES ☐ NO	Angina Pectoris	☐ YES ☐ NO	STDs	☐ YES ☐ NO
Heart Murmur	☐ YES ☐ NO	High Blood Pressure	☐ YES ☐ NO	Arteriosclerosis	☐ YES ☐ NO
Mitral Valve Prolapse	☐ YES ☐ NO	Artificial Heart Valve	☐ YES ☐ NO	Heart Pacemaker	☐ YES ☐ NO
Heart Surgery	☐ YES ☐ NO	Rheumatic Fever	☐ YES ☐ NO	Diabetes	☐ YES ☐ NO
Rheumatism	☐ YES ☐ NO	Cortisone Medicine	☐ YES ☐ NO	Drug Addiction	☐ YES ☐ NO
Stroke	☐ YES ☐ NO	Low Blood Pressure	☐ YES ☐ NO	Blood Disease	☐ YES ☐ NO
Hypoglycemia	☐ YES ☐ NO	Kidney Trouble	☐ YES ☐ NO	Artificial Joints	☐ YES ☐ NO
Ulcers	☐ YES ☐ NO	Thyroid Problems	☐ YES ☐ NO	Glaucoma	☐ YES ☐ NO
Cancer/Tumors	☐ YES ☐ NO	Emphysema	☐ YES ☐ NO	Tuberculosis	☐ YES ☐ NO
Asthma	☐ YES ☐ NO	Allergies, Hives or Hay Fever	☐ YES ☐ NO	Sinus Trouble	☐ YES ☐ NO
Radiation Therapy	☐ YES ☐ NO	Chemotherapy	☐ YES ☐ NO	Hep A, B or C	☐ YES ☐ NO
Breathing Problems	☐ YES ☐ NO	Shortness of Breath	☐ YES ☐ NO	Pain in Jaw	☐ YES ☐ NO
Congenital Heart Disease	☐ YES ☐ NO	HIV Positive/AIDS	☐ YES ☐ NO	Hemophilia	☐ YES ☐ NO
Anemia/Sickle Cell	☐ YES ☐ NO	Bruise Easily	☐ YES ☐ NO	Liver Disease	☐ YES ☐ NO
Epilepsy/Seizures	☐ YES ☐ NO	Fainting/Dizzy Spells	☐ YES ☐ NO	Jaundice	☐ YES ☐ NO
Developmentally Disabled	☐ YES ☐ NO	Alzheimer's Disease	☐ YES ☐ NO	Nervousness	☐ YES ☐ NO

Do your ankles swell during the day? ☐ YES ☐ NO Have you lost/gained more than 10lbs in past year? ☐ YES ☐ NO

Are you on a special diet? ☐ YES ☐ NO Do you have or have you had any disease, condition, or problem not listed? ☐ YES ☐ NO

If yes, please list: _____

Use tobacco products? ☐ YES ☐ NO If yes, How often? _____ Use alcohol products? ☐ YES ☐ NO If yes, How often? _____

Do you vape? ☐ YES ☐ NO If yes, How often? _____

FOR WOMEN ONLY:

Are you pregnant? ☐ YES ☐ NO (If yes, what month? _____) Nursing? ☐ YES ☐ NO Taking Birth Control ☐ YES ☐ NO

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

PATIENT SIGNATURE: _____ DATE: _____

PATIENT OR RESPONSIBLE PARTY: _____

Medical Review: Reviewed by: _____ Date: _____ Medical History Update by Patient: Initials: _____ Date:_____

Reviewed by: _____ Date: _____ Medical History Update by Patient: Initials: _____ Date:_____

Reviewed by: _____ Date: _____ Medical History Update by Patient: Initials: _____ Date:_____

FINANCIAL AND INSURANCE POLICIES

Thank you for choosing us as your dental care provider. We are anxious to serve you and are committed to providing the best care possible. Payment is due at time of treatment. In order to make your dental care financially comfortable, we offer the following financial options.

Payment in Full Courtesy (for fees totaling over $300.00).

A prepayment courtesy of 10% will be subtracted from total patient obligation (for patients without insurance) if the patient obligation is P**aid in Full.**

Outside financing (for fees totaling over $500.00)

We use different finance companies that specialize exclusively in helping the patient with larger dental cases. With fast approval over the telephone and no interest for 6 to 18 month if qualified, your payments can be much lower than those available through our office. There is no prepayment penalty and terms can be extended as far as 60 months. We will assist you in contacting them from our office.

On Account Accrued Payments

Payments may also be made to your account prior to having treatment completed. Once treatment has been pre-paid in full, treatment may begin.

Cancellation Policy

Henderson Family Dental requires 48 hours notice is given in any event of cancellation of scheduled visit. A $50.00 fee will be assigned to your account if failure to comply.

Pay As You Go

We accept Cash, Visa, MasterCard, Discover, American Express, Money Order, Personal Checks

INSURANCE

It is our pleasure to assist you in maximizing your insurance benefit by completing your claim forms. At the time of service we will ask you for your **estimated** co-payment. Please understand that this is only an **estimate**, and is based upon the information available to us.

Insurance benefit coverage depends solely on what your employer wishes to purchase. Some plans cover as little as 30% or as much as 100% of dental services, with most falling in the 40% to 80% range. Some plans base the amount of benefit on a schedule of fees arbitrarily developed by insurance companies. For this reason, you may receive a lower percentage than the reimbursement level indicated in your dental plan. For example, if your plan states that it will pay 80% of the cost of a specific treatment, it means 80% of the fee arbitrarily determined by the insurance company and not the actual fee charged by our office.

The **financial obligation for dental treatment is between you and our office. The insurance company is responsible to you, and not to our office.** We will assist you in any way we can. Once your insurance carrier has paid the claim, any difference will be due upon receipt of our statement. If for any reason we have not received your insurance carrier's payment 90 days after the claim was submitted, the remaining balance will be due and payable by you and subject to 21% APR. Should the account be referred to an attorney or collection agency, all cost of collection, including up to 50% collection fee, as well as court costs and a reasonable attorney fee will be the patient's responsibility.

Patient's Signature _____ Date_____

Parent or Responsible Party _____ Relationship to Patient _____

WE ARE PLEASED TO HAVE YOU AS OUR PATIENT

CONSENT TO PROCEED

I authorize Dr. Schwartz and/or such associates or assistants as he may designate to preform those procedures as may be deemed necessary or advisable to maintain my dental health or the dental health of any minor or individual for which I have responsibility, including arrangement and/or administration of any sedative (including nitrous oxide), analgesic, therapeutic, and/or other pharmaceutical agent(s), including those related to restorative, palliative, therapeutic, or surgical treatments.

I understand that the administration of local anesthetic may cause an untoward reaction or side effects, which may include, but are not limited to bruising, hematoma, cardiac stimulation, muscle stimulation, and temporary or rarely, permanent numbness. I understand that occasionally needles break and may require surgical retrieval. Occasionally drops of local anesthetic may contact eyes and facial tissues and cause temporary irritation.

I understand that as part of the dental treatment, including preventative procedures such as cleanings and basic dentistry, including fillings of all types, teeth may remain sensitive or even possibly quite painful both during and after completion of treatment. Dental materials and medications may trigger allergic or sensitivity reactions. This office retains the healthcare records of patients as part of regularly maintained records for five years after their receipt or production. After this period records may be disposed.

After lengthy appointments, jaw muscles may also be sore or tender. Holding one's mouth open can, in a predisposed patient, precipitate TMJ disorder. Gums and surrounding tissues may be sensitive or painful during and/or after treatment. Although rare, it is also possible for the tongue, cheek or other oral tissues to be inadvertently abraded or lacerated (cut) during routine dental procedures. In some cases, sutures or additional treatment may be required.

I understand that as part of dental treatment items including, but not limited to crowns, small dental instruments, drill components, etc. may be aspirated (inhaled into respiratory system) or swallowed. This unusual situation may require a series of x-rays to be taken by a physician or hospital and may, in rare cases, require bronchoscopy or other procedures to ensure safe removal.

I understand that the need to disclose to the dentist any prescription drugs that are currently being taken or that have been taken in the past. I understand that taking the class of drugs that is prescribed for the prevention of osteoporosis, such as Fosamax, Boniva or Actonel, may result in complications of non-healing of the jaw bones following oral surgery or tooth extractions.

I do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any, which may be associated with standard dental preventative and operative treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit or the benefit of my minor child or ward. I acknowledge that the nature and purpose of the foregoing procedures have been explained to me if necessary and I have been given the opportunity to ask questions.

Patient Name: _____

Signature: _____ Date: _____

(Patient, legal guardian or authorized agent of patient)

Witness: _____ Date: _____

DENTAL INFORMATION RELEASE

Name: _____ Date: _____

{ } I authorize the release of information including the diagnosis, records, examination rendered to me and claims/financial information. This information may be released to:

{ } Spouse: _____

{ } Child(ren): _____

{ } Other: _____

{ } Information is not to be released to anyone.

May we phone, email or send a text to confirm your appointment? ☐ YES ☐ NO

May we leave a detailed message on your answering machine or cell phone? ☐ YES ☐ NO

May we send your account statements via email or text? ☐ YES ☐ NO

Email Address: _____

AUTHORIZATION FOR SIGNATURE ON FILE

I, _____ and/or _____ Hereby authorize the office of Henderson Family Dental to affix my name to any and all claims or documents as related to any and all health benefits due me and my dependents through my Insurance.

I hereby authorize payment of dental benefits, otherwise payable to me, directly to the office listed above. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan. To the extent permitted under applicable law, I authorize release of any information relating the claim. This "Authorization" will be valid from this date and shall expire in one year. A photocopy of this document may act as an original.

ACKNOWLEDGEMENT OF RECIEPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided a copy of Henderson Family Dental's Notice of Privacy Practices, which has an effective date of 01/05/2023 which describes how my health information may be used and disclosed.

I understand that you have the right to change the Notice of Privacy Practices any time, and that I will be provided a copy of any updated version. And that I may contact you at any time to request a current Notice of Privacy Practices.

My signature below acknowledges that I have completed the above dental release, been provided with a copy of the Notice of Privacy Practices, and I have read and agree to the Authorization for signature on file:

Patient Name: _____

Signature: _____ Date: _____

(Patient, legal guardian or authorized agent of patient)

Witness: _____ Date: _____

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ORAL CANCER SCREENING CONSENT FORM

Our office strives to bring its patients state-of-the art technology to provide you with the latest advancements in oral health. We have recently introduced the OralID screening device into our office. The OralID screening will allow us to visualize any oral mucosal abnormalities including cancer and dysplasia (Pre-cancer) before they can be detected with the naked eye. The procedure is quick, painless and no rinses or dyes are used.

Similar to other cancers, early detection of Oral Cancer is critical. Studies have shown that early detection of oral cancer with technologies like OralID dramatically improves the survivability of the disease. If oral cancer is detected in its later stages, which typically occurs during conventional oral cancer screening, the chances of survival are dramatically reduced.

Who is at Risk?

- Age – 17+ years
- Tobacco Use
- Alcohol Use
- HPV infection

If you have any questions about risk factors, please feel free to talk to our hygiene staff. We recommend all of our patients be screened with the OralID.

How much does the screening cost?

- $40 unless covered by patient insurance

☐ YES, I request that your staff perform a screening with the OralID.

Signature: _____ Date: _____

☐ NO, I prefer to not have this screening at this visit.

Signature: _____ Date: _____