

**Please complete all information as completely and accurately as possible.  
This information is important in ensuring your health is protected.**

**MEDICAL HISTORY**

**Patient Name:** \_\_\_\_\_

Name of Patient's Primary Care Physician? \_\_\_\_\_

Office Phone (\_\_\_\_) \_\_\_\_\_ Date of Last Visit \_\_\_\_\_ Reason for visit \_\_\_\_\_

Office Address \_\_\_\_\_  
Street City State ZIP

Name(s) & Specialty(s) of any other Physicians you see regularly \_\_\_\_\_  
\_\_\_\_\_

1. Are you regularly taking any medications (prescribed or over the counter), drugs, or herbs? Y / N  
If yes, please provide a list of **ALL** medications/drugs/herbs you take and why you take them:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. Are you allergic to or have you had an adverse reaction to ANY medication? Y / N  
If yes, please specify: \_\_\_\_\_

\_\_\_\_\_

3. Do you have any other allergies or hyper-sensitivity reactions? Y / N  
If yes, please specify: \_\_\_\_\_

\_\_\_\_\_

4. Do you have or have you had any of the following (please circle ALL that apply):

- |                        |                            |                      |                              |
|------------------------|----------------------------|----------------------|------------------------------|
| Heart Attack           | High Blood Pressure        | Liver Disease        | Asthma                       |
| Chest Pains (Angina)   | Low Blood Pressure         | Hepatitis / Jaundice | Emphysema                    |
| Cardiac Pacemaker      | Bleeding Problems          | Cancer               | Tuberculosis                 |
| Artificial Heart Valve | Anemia                     | Chemotherapy         | Arthritis/Joint Problems     |
| Bacterial Endocarditis | Ulcers                     | Radiation Therapy    | Joint Replacement            |
| Rheumatic Fever        | Diabetes                   | Glaucoma             | Latex Allergy                |
| Heart Murmur           | Difficulty Healing         | Stroke               | HIV/AIDS                     |
| Mitral Valve Prolapse  | Kidney Disease/Dysfunction | Epilepsy/Convulsions | Sexually Transmitted Disease |

Other Condition(s) not listed: \_\_\_\_\_

5. Are you currently experiencing any health problems? Y / N  
If yes, please specify: \_\_\_\_\_

6. Are you currently undergoing any medical treatment(s)? Y / N  
If yes, please specify: \_\_\_\_\_

7. Do you smoke or use any type of tobacco and/or marijuana products? Y / N  
If yes, how many years / how much per day average?: \_\_\_\_\_ / \_\_\_\_\_

8. Do you use alcoholic beverages? Y / N

**\*\* WOMEN ONLY \*\***

9. Are you currently pregnant? If yes, due date: \_\_\_\_\_ Y / N

10. Are you currently nursing? Y / N

11. Are you currently using birth control (pills, injections, implants)? Y / N  
If yes, please specify: \_\_\_\_\_

**PERSONAL INFORMATION**

Patient Name \_\_\_\_\_ Preferred Name \_\_\_\_\_  
Last First Middle

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_\_ Gender: M F SS# \_\_\_\_-\_\_\_\_-\_\_\_\_

Drivers License # \_\_\_\_\_ State \_\_\_\_ Exp. Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Marital Status (circle one): Married Legally Separated Divorced Single

Address \_\_\_\_\_  
Street City State ZIP

Phone: Home (\_\_\_\_) \_\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_\_ Work (\_\_\_\_) \_\_\_\_\_ ext \_\_\_\_\_

Email: \_\_\_\_\_

*If patient is a minor:*

Parent/Legal Guardian Name \_\_\_\_\_ Relationship \_\_\_\_\_  
First Last

**Communication Preferences:** We use text and email for most office messages (*i.e.* appointment reminders, newsletters, birthday wishes). We will still call if you prefer. How should we contact you? (*please circle ALL that apply*)

Text Email Phone call

Whom may we thank for referring you / How did you hear about us? \_\_\_\_\_

**DENTAL HISTORY**

- 1. Reason for today's visit \_\_\_\_\_
- 2. Do you currently have any pain or discomfort in your mouth? Y / N  
If yes, please describe: \_\_\_\_\_
- 3. Do you ever have any TMJ pain, including pain opening/closing your mouth or when chewing? Y / N  
If yes, please describe: \_\_\_\_\_
- 4. Do you have any sores or lumps in your mouth? Y / N  
If yes, please describe: \_\_\_\_\_
- 5. Have you had difficulty with any previous dental treatment? Y / N  
If yes, please describe: \_\_\_\_\_
- 6. Are you interested in knowing your options for cosmetic dental treatment? Y / N  
If yes, please describe: \_\_\_\_\_

**AUTHORIZATION AND RELEASE**

I certify that the personal information and medical & dental history information provided on this form is accurate and complete to the best of my knowledge. I understand that providing incorrect or incomplete information can be dangerous to my health or the health of the patient named. I will notify this office of any changes in health status for myself or the patient named at each visit. I have had any questions answered to my satisfaction.

I authorize the release of any and all of the above information, including any diagnoses and records of any treatment or exam done in this office or obtained from any other office, to third party payors and/or other health care practitioners.

I consent to all dental procedures and anesthetics necessary for treatment of myself or the above named patient.

X \_\_\_\_\_ Date \_\_\_\_\_  
Signature of Patient (or parent/guardian if patient is a minor)

**\*\* FOR OFFICE USE ONLY \*\***

NOTES: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

X \_\_\_\_\_ Date \_\_\_\_\_  
Signature of Dentist

**FINANCIAL AGREEMENT**

Patient Name \_\_\_\_\_  
last first middle

Responsible Party\* \_\_\_\_\_  
last first middle

*\* This is the person financially responsible for payment for all services rendered to the patient, regardless of insurance coverage or any other program coverage.*

Address \_\_\_\_\_  
Street City State ZIP

Phone: Home (\_\_\_\_) \_\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_\_ Work (\_\_\_\_) \_\_\_\_\_ ext \_\_\_\_\_

Email: \_\_\_\_\_

Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Social Security # \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Relationship to patient \_\_\_\_\_

I agree to be fully financially responsible for complete payment for all services rendered to the above patient, regardless of insurance payment, and understand that full payment is due at the time service is rendered unless prior arrangements have been made with Dr. Noorda's office.

I authorize and request my insurance company to pay directly to this office any benefits that would otherwise be payable to me for procedures billed from this office. I understand that my dental insurance carrier may pay less than the estimated or actual bill for services, and that I will be fully responsible for any charges my insurance does not pay.

I understand that a 1.5% monthly finance charge will be added to any balance due over 60 days from the date billed, regardless of expectation of payment from insurance if applicable, and that I will pay said interest.

If my account is turned over to a collection agency or attorney for failure to pay my bill, I agree to pay all collection and attorney's fees in addition to the outstanding balance and any interest accrued.

X \_\_\_\_\_ Date \_\_\_\_\_  
Signature of Responsible Party

**INFORMATION UPDATES** The following changes have occurred since my last update:

<u>Today's Date</u>	<u>Changes to Medical/Dental Health and/or Medications, Insurance, and/or Personal Information</u> (please write "No Change" if nothing has changed since your last update)	<u>Initials</u>
1 _____	_____	1 _____
2 _____	_____	2 _____
3 _____	_____	3 _____
4 _____	_____	4 _____
5 _____	_____	5 _____
6 _____	_____	6 _____

**AUTHORIZED RELEASE OF INFORMATION TO INDIVIDUALS**

I authorize, without additional permission from me and until I revoke this permission in writing, the release of any and all of the information on these forms, as well as any diagnoses and records of any treatment or exam done in this office or obtained from any other office, and/or any costs or financial information regarding my or the above named patient's treatment in this office, to the following individuals:

- 1. \_\_\_\_\_ 3. \_\_\_\_\_
- 2. \_\_\_\_\_ 4. \_\_\_\_\_

X \_\_\_\_\_ Date \_\_\_\_\_  
Signature of Patient (or parent/guardian if patient is a minor)

**DENTAL INSURANCE INFORMATION**

Name of Primary Insured \_\_\_\_\_  
last first middle

Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Social Security # \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Relationship to patient \_\_\_\_\_

Employer \_\_\_\_\_ Employer phone (\_\_\_\_) \_\_\_\_\_

Insurance Company \_\_\_\_\_ Insurance phone (\_\_\_\_) \_\_\_\_\_

Insurance Address \_\_\_\_\_

Group # \_\_\_\_\_ Primary ID # \_\_\_\_\_ Patient's ID # \_\_\_\_\_

This plan is a: *(circle one)* PPO HMO Unsure

*If you have additional dental insurance please complete this section:*

Name of Primary Insured \_\_\_\_\_  
last first middle

Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Social Security # \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Relationship to patient \_\_\_\_\_

Employer \_\_\_\_\_ Employer phone (\_\_\_\_) \_\_\_\_\_

Insurance Company \_\_\_\_\_ Insurance phone (\_\_\_\_) \_\_\_\_\_

Insurance Address \_\_\_\_\_

Group # \_\_\_\_\_ Primary ID # \_\_\_\_\_ Patient's ID # \_\_\_\_\_

This plan is a: *(circle one)* PPO HMO Unsure

**MEDICAL INSURANCE INFORMATION**

Name of Primary Insured \_\_\_\_\_  
last first middle

Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Social Security # \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Relationship to patient \_\_\_\_\_

Employer \_\_\_\_\_ Employer phone (\_\_\_\_) \_\_\_\_\_

Insurance Company \_\_\_\_\_ Insurance phone (\_\_\_\_) \_\_\_\_\_

Insurance Address \_\_\_\_\_

Group # \_\_\_\_\_ Primary ID # \_\_\_\_\_ Patient's ID # \_\_\_\_\_

This plan is a: *(circle one)* PPO HMO Unsure

**EMERGENCY CONTACT INFORMATION**

Person to contact \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Phone: Home (\_\_\_\_) \_\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_\_ Work (\_\_\_\_) \_\_\_\_\_ ext \_\_\_\_\_

Alternate contact \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Phone: Home (\_\_\_\_) \_\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_\_ Work (\_\_\_\_) \_\_\_\_\_ ext \_\_\_\_\_



## PATIENT CONSENT & ACKNOWLEDGMENT FORM

By signing below, you consent to the use and disclosure of your protected health information by Brett Noorda D.M.D., our staff, and our business associates for treatment, payment and health care operations. For a more detailed description of uses and disclosures for these purposes, please review our Notice of Information Practices ("Notice"). You have the right to review our Notice prior to signing this consent. The terms of this Notice may change. If the terms do change, you may obtain a revised Notice by simply contacting this office at (702) 456-7403 and requesting a revised Notice. We will also post any revised notice in the office.

You have the right to request that we restrict our uses or disclosures of your protected health information that we are otherwise permitted to make for treatment, payment and health care operations, although we are not required to agree to these restrictions. However, if we agree to further restrictions, they are binding on us. Finally, you may refuse to consent to the use or disclosure of your protected health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Protected Health Information (PHI).

THIS FORM IS ALSO USED TO OBTAIN ACKNOWLEDGMENT OF RECEIPT OF OUR NOTICE OF PRIVACY PRACTICES OR TO DOCUMENT OUR GOOD FAITH EFFORT TO OBTAIN THAT ACKNOWLEDGMENT.

I HAVE REVIEWED, UNDERSTAND AND AGREE TO THE CONTENT OF THE NOTICE OF PRIVACY.

Name \_\_\_\_\_ Date \_\_\_\_\_

**For Office Use Only: If patient declines to sign this Consent Form,** Please specify the exact reason why patient chose not to sign.

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EMPLOYEE SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_



## APPOINTMENT AGREEMENT

Here at Dental Excellence, we recognize that your time, like our time, is valuable. Therefore, we try very hard to respect your time by doing things a little differently.

- First, we do not overbook our schedule. This means that when you are scheduled for an appointment with either the doctor or hygienist, there is no one else scheduled to see that person—this time is for you.
- Second, we add extra time into every appointment for the unforeseen problems that arise during treatment every day (like difficulty getting numb, or more severe-than-expected decay, etc.).

These two things help us run on-time as much as possible while still providing you with the best of care.

Many offices double-book (schedule two patients at the same time) because it increases their profit and maximizes their time usage, but it does so at the expense of *your* quality of care and *your* time. *Because we value you, we have chosen to forego the increased profit of double-booking to increase the quality of care you receive in our office and save you time. In exchange, we expect you to invariably keep your appointments and arrive on time.*

**In order for us to continue to provide you with this quality of care, it is necessary for us to assess a fee for each *missed appointment or late-notice cancellation*. The fees for missed appointments, or appointments canceled or rescheduled on short-notice (less than 36 hours) will be assessed per appointment as follows:**

**Doctor appointments:**

**\$60.00 up to 30 min.**

**\$15.00 for each additional 15 min. (up to \$100 max)**

**Hygienist appointments:**

**\$40.00**

Whenever we are able to fill an appointment slot left open because of a short-notice cancellation, you will only be charged for the time not filled. We also realize that some appointments must be missed or rescheduled on short-notice due to emergencies that arise in your life, and those reasons will be considered. However, all judgments on whether or not these fees are assessed will rest solely with our office and are binding, and only one “forgiveness” will be granted any individual per calendar year.

By signing below, you confirm that you have read this notice, that you understand it, and that you are willing to accept the obligations stated therein.

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**I agree that I will keep any and all appointments made with Dental Excellence for myself and will ensure that my dependents keep theirs. I understand that the fees as described above will be assessed to my account if I or my dependents miss an appointment, or reschedule or cancel an appointment with less than 36-hours notice. I also accept and agree that I am responsible for and will pay any fees assessed to my account for any missed appointments, or appointments rescheduled or canceled with less than 36-hours notice, whether for myself or my dependents. I understand that such fees will not be covered in any way by my insurance and that 100% of the fees will be my responsibility. I also agree that payment of such fees will be necessary before any future appointments will be made. I accept that all judgments for assessing the fees will rest solely with Dental Excellence.**

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Signature of patient (or if patient is a minor, of parent or guardian)

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Date