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 _____ (Last) _____ (First) _____ (Middle) Preferred Name _____

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 _____ (First) _____ (Last) Relationship _____

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

PREFERRED PHARMACY FOR MY PRESCRIPTIONS

Pharmacy Name: _____

Phone number: _____

Pharmacy address: _____

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)

INFORMATION UPDATES

The following changes have occurred since my last update:

Today's Date	*Changes to Medical/Dental Health and/or Medications, Insurance, and/or Personal Information* (please write "No Change" if noting has changed since your last update)	*Initials*
1_____	_____	1_____
2_____	_____	2_____
3_____	_____	3_____
4_____	_____	4_____
5_____	_____	5_____
6_____	_____	6_____

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.

_____

_____

_____

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 48 hours) will be assessed per appointment as follows:

Doctor appointments:
$100.00 up to 30 min. $20 for each additional 15 min

Hygienist appointments:
$75.00 for prophy $95-$125 for perio maintenance, deep cleaning or SRP appointments

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.

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 48-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.

_____ _____

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

2026 FINANCIAL AGREEMENT

I understand and agree that I am financially responsible for all charges for any and all services rendered.

I understand that while my insurance may confirm my benefits, confirmation of benefits is not a guarantee of payment and that I am responsible for any unpaid balance.

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 for services I have received. Because my care needs and treatment plan are determined by me and my doctor, I understand that I will pay the difference if my insurance does not cover/allow a treatment, downgrades, or combines treatments for any treatment I have done.

I understand and agree that it is my responsibility to know if my insurance has any deductible, co-payment, co-insurance, out-of-network, usual and customary limit, prior authorization requirements or any other type of benefit limitation for the services I receive and I agree to make payment in full for my care. I understand that a pre-determination from insurance is not a guarantee of payment, and agree that I will be responsible for the amount in full.

I agree to inform the office of any changes in my insurance coverage. If my insurance has changed or is terminated at the time of service, I agree that I am financially responsible for the balance in full.

If I am a Medicare patient, I understand that I will not be able to use Medicare benefits in this office, and I will be required to sign a Private Contract for care in this office (this is mandated by Medicare).

If I do not provide the office with the proper information for my secondary insurance, the secondary will not be billed. It will be my responsibility to pay the balance and then file a claim with the secondary for reimbursement.

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 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 fees up to 35% as well as any applicable attorney's fees in addition to the outstanding balance and interest accrued.

By signing this form, I consent to the use and disclosure of protected health information about me for treatment, payment and health care operations, and/or as required by law. I have the right to revoke this Consent, in writing, signed by me. However, such revocation shall not affect any disclosures already made in compliance with my prior Consent. Dr. Noorda provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Signature of Responsible Party below (the person financially responsible for all services rendered to the patient, regardless of insurance or any other program coverage) :

_____ _____

signature **date**