GREAT BASIN DENTAL

## PATIENT INFORMATION

Last Name_____First Name_____Middle Name_____

Is there a name you prefer to be called _____ Birthday_____ Male / Female

Hobbies_____

## MEDICAL HISTORY

*Please check any that apply to you*

- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Heart trouble
- ☐ Heart murmur
- ☐ Angina
- ☐ Stroke
- ☐ Pacemaker
- ☐ Rheumatic fever
- ☐ Daily Aspirin regimen
- ☐ Asthma
- ☐ Asthma Inhaler
- ☐ Sinus problems
- ☐ Artificial joints
- ☐ Arthritis
- ☐ Diabetes
- ☐ Fainting spells
- ☐ Epilepsy
- ☐ MS
- ☐ Persistent cough
- ☐ Tuberculosis
- ☐ Malignancies
- ☐ Radiation therapy
- ☐ Chemotherapy
- ☐ Frequent headaches
- ☐ Kidney problems
- ☐ Jaundice
- ☐ Venereal Disease
- ☐ Hepatitis/ Type _____
- ☐ Aids/HIV Positive
- ☐ Anemia

Do you have any disease, condition or problem not listed above? _____

Do you bleed easily or for a long time when you have been cut? Yes / No

Are you currently under the care of a physician? *Yes* / *No* If Yes, name of physician_____

## DENTAL HEALTH HISTORY

*If there is anything about your smile you could change what would it be?*_____

*Please check any that apply to you*

- ☐ Orthodontic treatment
- ☐ Oral surgery
- ☐ Periodontal (gum) surgery
- ☐ Bleeding or sore gums
- ☐ Pain when eating or drinking
- ☐ Sore jaws or 'popping' in jaw
- ☐ History of TMJ/ joint problems
- ☐ Have any recurring non-healing sores in the mouth, gums, cheek, tongue, etc

*Yes* / *No* Have you ever had an unfavorable dental experience?
*Yes* / *No* Have you ever had injury to your face, jaws or teeth?
*Yes* / *No* Are you afraid of losing your teeth?
*Yes* / *No* Do you have missing teeth you would like replaced?

Have you ever had an unusual reaction to a dental anesthetic, Penicillin, Barbiturates, Aspirin, codeine, Sulfa or other ? No / Yes (please list below)

If you are a new patient to our office:
When was your last comprehensive dental examination? _____When were your last dental x-rays? _____

| MEDICATIONS or HERB/ VITAMINS REASONS FOR TAKING | MEDICAL ALERTS |
|---|---|
| | ALLERGIES: |
| | PRECAUTIONS: |
| | PRE-MEDICATION: |

(For Women) *Are you pregnant?* Yes / No *DUE DATE:* *Are you taking an oral contraceptive, such as the pill?* Yes / No

CONSENT: *I grant authority to the Doctor to perform dental procedures and treatments. This may include the administration of medicine, local anesthesia, x-rays, and dental procedures including extractions and surgery. I understand that possible complications might occur from the proposed treatment and that a perfect result cannot always be guaranteed.*

| *Date* | *Signature* | *Update/ Changes* |
|---|---|---|
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GREAT BASIN DENTAL

STEPHEN C. PRICE, D.D.S. & CLAYTON T. NEILSON, D.M.D.

# NOTICE OF PRIVACY PRACTICES

**THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.**

**PLEASE REVIEW IT CAREFULLY.**
**THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.**

## OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 04/14/03, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

## USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

**Treatment:** We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

**Payment:** We may use and disclose your health information to obtain payment for services we provide to you.

**Healthcare Operations:** We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

**Your Authorization:** In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

**To Your Family and Friends:** We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

**Persons Involved In Care:** We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

**Marketing Health-Related Services:** We will not use your health information for marketing communications without your written authorization.

**Required by Law:** We may use or disclose your health information when we are required to do so by law.

**Abuse or Neglect:** We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

GREAT BASIN DENTAL

STEPHEN C. PRICE, D.D.S.
CLAYTON T. NEILSON, D.M.D.
2552 Idaho Street, Elko NV 89801 (775)738-7666

# CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

**Purpose of Consent:** By signing this form, you will consent to our use and disclosure of protected health information to carry out treatment, payment activities, and healthcare operations.

**Disclosing Family Information:** We will make every effort to protect yours and your family's health information. Inquiries concerning treatment, payment, or other personal information regarding your account will be accessible to those persons on your account. Please notify us as soon as possible as to any changes in family status so that we may update your records.

**Appointments:** Once an appointment is made please remember this time has been reserved for you. A minimum charge will be made for failed or canceled appointments without prior notification of 24 hours.

**Insurance and Fees:** To avoid misunderstanding regarding dental insurance, we wish our patients to know that all professional services are charged directly to the patient and that they are personally responsible for payment of all fees. We will prepare necessary forms to help you obtain your benefits from insurance companies. We do not render services on the basis that insurance companies will pay all our fees. All fees are based on our ability to provide the highest quality of dental care to you. **The patient is responsible for all account balances regardless of insurance benefits.**

*I authorize the release of treatment information and hereby assign any insurance benefits to the Doctor.*

**Right to Revoke:** You will have the right to revoke this Consent at any time by giving us written notice of your revocation. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation and that we may decline to treat you or to continue treating you if you revoke this Consent.

**Our Legal Duty:** We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you a copy of this office's Notice of Privacy Practices.

**AUTHORIZATION**

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

Name of PATIENT (please print) _____

Patient or Guardian Signature: _____ Date _____

Relationship to Patient: _____

FOR OFFICE USE ONLY

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

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (please specify) _____ date _____

# GREAT BASIN DENTAL

Please fill in completely...
If you have recently completed this blue form in our office,
let us know so you don't have to do it again!

**PERSON RESPONSIBLE FOR THIS ACCOUNT**

Name_____ Birth Date_____

Cell Phone _____ Home Phone _____ Work Phone _____

Mailing Adress_____City_____Zip_____

Place of Employment _____

Insured Social Security Number _____ Insured Date of Birth_____

SPOUSE

Name_____ Birth Date_____

Cell Phone _____Place of Employment _____ Work Phone _____

*Who may we thank for referring you to our office?* _____

**PLEASE LIST ALL *OTHER* FAMILY MEMBERS YOU AUTHORIZE TO BE ON THIS ACCOUNT .**

| *Relationship* *Check one* | *LAST* *FIRST* *INITIAL* | **Birthday** *M / D / Y* | **Sex** | *Insurance* *Check all that apply* |
|---|---|---|---|---|
| Child ☐ Other ☐ | | | M ☐ F ☐ | None ☐ Primary ☐ Secondary ☐ |
| Child ☐ Other ☐ | | | M ☐ F ☐ | None ☐ Primary ☐ Secondary ☐ |
| Child ☐ Other ☐ | | | M ☐ F ☐ | None ☐ Primary ☐ Secondary ☐ |
| Child ☐ Other ☐ | | | M ☐ F ☐ | None ☐ Primary ☐ Secondary ☐ |
| Child ☐ Other ☐ | | | M ☐ F ☐ | None ☐ Primary ☐ Secondary ☐ |

**Insurance and Fees:** To avoid misunderstanding regarding dental insurance, we wish our patients to know that all professional services are charged directly to the patient and that they are personally responsible for payment of all fees. We will prepare necessary forms to help you obtain your benefits from insurance companies. We do not render services on the basis that insurance companies will pay all our fees. All fees are based on our ability to provide the highest quality of dental care to you. **The patient is responsible for all account balances regardless of insurance benefits.**

**DATE**_____**SIGNATURE**_____