Vista Dental - 3960 W. Craig Rd Suite 110 N. Las Vegas, NV 89032 (702)464-3000

PATIENT INFORMATION - CONFIDENTIAL

Name _____ Social Security # _____
Last First Middle Email _____
Address _____ **Home Phone** _____
City_____ State _____ Zip _____ **Cell Phone** _____
Sex: M ___ F ___ Birthdate _____ Single ___ Married ___ Widowed ___ Separated ___ Divorced ___
Employer _____ Occupation _____ **Work phone** _____
Employer address _____ City _____ State ____ Zip _____
In case of emergency who should be notified? _____ Phone _____

RESPONSIBLE PARTY AND INSURANCE INFORMATION

If yourself is the responsible party, skip the following section.
Name of person responsible _____ Relation to patient _____
Address _____ **Home Phone** _____
City_____ State _____ Zip _____ **Cell Phone** _____
Birthdate _____ Social security # _____ **Work phone** _____

Method of payment (Check one) Cash ___ Insurance ___ Medicaid ___ Other (specify)_____

If you have dental insurance, please fill out the following section.
Name of insured _____ Relation to patient _____
Birthdate of insured _____ Social security # of insured _____
Employer _____ Work phone _____
Employer address _____
Insurance company _____ Group # _____ Union or local # _____

If you have additional dental insurance, please fill out the following section.
Name of insured _____ Relation to patient _____
Birthdate of insured _____ Social security # of insured _____
Employer _____ Work phone _____
Employer address _____
Insurance company _____ Group # _____ Union or local # _____

HOW DID YOU HEAR ABOUT OUR OFFICE?

__ Referred by a friend __ Yellow pages __ Relative __ Insurance plan __ Welcome wagon
__ Other _____ __ TV/Radio Ad __ Newspaper ad __ Direct mail __ Sign by Building

If you were referred, whom may we thank for referring you? _____

AUTHORIZATION AND RELEASE

I have read and answered the above questions to the best of my knowledge. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I authorize the doctor to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents. I authorize the use of this signature on all insurance submissions.

_____ _____
Signature of patient or parent/guardian if minor Date

(Please continue on back)

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DENTAL HISTORY

Reason for today's visit _____ Date of last dental care _____
Former dentist _____ Date of last cleaning and x-rays _____
Reason for changing dentist _____
Do you need to be premedicated before dental treatment? Y/N
Do you have problem with prolonged bleeding? Y/N
Circle **Y for Yes and N for No** for any of following concerns that you may have

Do you have tooth ache?	Y/N	Loose or broken teeth?	Y/N	Jaw joint problem (TMJ)?	Y/N
Sensitivity to hot or cold?	Y/N	Sensitivity to sweet?	Y/N	Clenching/grinding teeth?	Y/N
Does your gum bleed?	Y/N	Food jam between teeth?	Y/N	Bad Breadth?	Y/N

Do you have any other problem not mentioned above? Y/N If Yes, please describe _____
_____
Do you want whiter teeth? Y/N **Would you prefer tooth-colored filling?** Y/N
Do you wear dentures or partials? Y/N If yes, date of placement _____
How often do you brush? _____ How often do you floss? _____

MEDICAL HISTORY

Physician's name _____ Phone _____
I consider my health to be: (Please check one) __ Excellent __ Good __ Fair __ Poor
Have you had any serious illness or operation? Y/N If Yes, date and describe _____
_____
Have you ever had a blood transfusion? Y/N If Yes, give approximate dates _____
Have you ever taken medication for osteoporosis known as "**bisphosphonate**?" Y/N
(Women) Are you pregnant? Y/N Nursing? Y/N Taking birth control pills? Y/N
Do you have or had any of the following? Please circle **Y for Yes and N for No**

AIDS/HIV +	Y/N	Cancer	Y/N	Glaucoma	Y/N	Psychiatric care	Y/N
Anaphylaxis	Y/N	Chemical/alcohol addiction	Y/N	Heart murmur	Y/N	Radiation treatment	Y/N
Anemia	Y/N	Chemotherapy	Y/N	Heart problems	Y/N	Rapid weight loss	Y/N
Angina/chest pain	Y/N	Circulatory problems	Y/N	Hepatitis: Type __	Y/N	Rheumatic fever	Y/N
Arthritis	Y/N	Congenital heart lesions	Y/N	High blood pressure	Y/N	Scarlet fever	Y/N
Artificial heart valves	Y/N	Cortisone treatment	Y/N	Jaundice	Y/N	Swelling of feet or ankles	Y/N
Artificial joints	Y/N	Cough persistent or bloody	Y/N	Kidney disease	Y/N	Thyroid disease	Y/N
Asthma	Y/N	Diabetes	Y/N	Leukemia	Y/N	Tobacco habit	Y/N
Bleeding abnormally	Y/N	Emphysema	Y/N	Liver disease	Y/N	Tuberculosis	Y/N
Blood disease	Y/N	Epilepsy	Y/N	Mitral valve prolapse	Y/N	Tumor/Ulcer	Y/N
Blood thinner drug	Y/N	Fainting	Y/N	Pacemaker	Y/N	Venereal diseases	Y/N

Do you have any problem not mention above? Y/N If yes, describe_____
_____
List **medications** you are currently taking, if any:
_____
_____
_____

Are you **allergic** to any of the following? **Circle Y or N**

Aspirin	Y/N	Barbiturates	Y/N	Codeine	Y/N
Metal (i.e. nickel)	Y/N	Penicillin	Y/N	Latex	Y/N
Local anesthetic	Y/N	Sedatives	Y/N	Other	Y/N

Comments_____
_____

ACKNOWLEDGEMENT

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is a change in my medical status, I will inform the dentist.
Signature of patient or guardian _____ Date _____
Medical history reviewed by _____ Date _____
(Doctor signature)

FINANCIAL POLICIES

PATIENTS WITH INSURANCE – Upon your first visit we will verify your insurance coverage. For all visits we will file insurance claims for you as a courtesy, at no charge. However, please remember that you are ultimately responsible for your account, not your insurance company. Also be aware that some of the services provided may be non-covered services. **You must pay your deductible, co-payment, and fees for services not covered at the time of treatment**. You are still responsible for these fees even if you have **dual insurance** coverages. We can only make **estimates** regarding your insurance payments based on the information that is given to us at the time of verification. While we do our best to determine your plan benefits, it is your responsibility as a patient to know your plan details such as non-covered services, waiting period, annual maximum, etc. We will attempt to collect all fees due from your insurance carrier in a timely manner, however, fees not paid by the carrier within **45 days** are due and payable by the patient or the responsible party.

PATIENTS WITHOUT INSURANCE – **payment is due in full** at time of treatment unless prior arrangements have been approved.

COLLECTION – If your account remains unpaid past **45 days**, it will be sent to a collection agency for non-payment and/or delinquent matters. **All accounts sent to collections are subject to a collection fee equal to ½ the outstanding balance and possible other legal costs in addition to the balance that is owed**.

RETURNED CHECKS – There is a charge of **$35** for returned checks.

X-RAY DUPLICATION – There is a charge of **$25** for duplicating x-rays.

CANCELLATION OR NO-SHOW APPOINTMENT

As a patient your scheduled appointment is as important to us as it is to you. We try to confirm your appointment the day before, but it is your responsibility to keep track of your own appointment. We request that you give us **24 hours advance notice** should you have to cancel or re-schedule an appointment. Any no show without advance notice will result in a **$25 charge** to compensate for the time reserved for your visit.

ACKNOWLEDGEMENT AND CONSENT

I have read and understood the content of the above policies. I agree to comply with all policies. If you have any question regarding this policy, please ask us.

NAME (Print)_____

Signature _____ Date _____

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.

State and Federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this Notice. We must follow the privacy practices as described below. This Notice will take effect on ***09/01/2015*** and will remain in effect until it is amended or replaced by us.

It is our right to change our privacy practices provided law permits the changes. Before we make a significant change, this Notice will be amended to reflect the changes and we will make the new Notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our Notice effective for all health information maintained, created and/or received by us before the date changes were made.

You may request a copy of our Privacy Notice at any time by contacting our Privacy Officer, ***Dr. Ben Truong***. Information on contacting us can be found at the end of this Notice.

TYPICAL USES AND DISCLOSURES OF HEALTH INFORMATION

We will keep your health information confidential, using it only for the following purposes:

Treatment: We may use your health information to provide you with our professional services. We have established "minimum necessary or need to know" standards that limit various staff members' access to your health information according to their primary job functions. Everyone on our staff is required to sign a confidentiality statement.

Disclosure: We may disclose and/or share your healthcare information with other health care professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends and/or other persons you choose to involve in your care, only if you agree that we may do so.

Payment: We may use and disclose your health information to seek payment for services we provide to you. This disclosure involves our business office staff and may include insurance organizations or other businesses that may become involved in the process of mailing statements and/or collecting unpaid balances.

Emergencies: We may use or disclose your health information to notify, or assist in the notification of a family member or anyone responsible for your care, in case of any emergency involving your care, your location, your general condition or death. If at all possible we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated we will use our professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgment to make reasonable inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays or other similar forms of health information and/or supplies unless you have advised us otherwise.

Healthcare Operations: We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, outside health or management reviewers and individuals performing similar activities.

Required by Law: We may use or disclose your health information when we are required to do so by law. (Court or administrative orders, subpoena, discovery request or other lawful process.) We will use and disclose your information when requested by national security, intelligence and other State and Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.

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. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.

Public Health Responsibilities: We will disclose your health care information to report problems with products, reactions to medications, product recalls, disease/infection exposure and to prevent and control disease, injury and/or disability.

Marketing Health-Related Services: We will not use your health information for marketing purposes unless we have your written authorization to do so.

National Security: The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence or other national security activities, we may disclose it to authorized federal officials.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders, including, but not limited to, voicemail messages, postcards or letters.

YOUR PRIVACY RIGHTS AS OUR PATIENT

Access: Upon written request, you have the right to inspect and get copies of your health information (and that of an individual for whom you are a legal guardian.) There will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit an appropriate request form. Contact our Privacy Officer for a copy of the Request Form. You may also request access by sending us a letter to the address at the end of this Notice. Once approved, an appointment can be made to review your records. Copies, if requested, will be **$0.25** for each page and the staff time charged will be a **$10** flat fee for the time required to locate and copy your health information. If you want the copies mailed to you, postage will also be charged. If you prefer a summary or an explanation of your health information, we will provide it for a fee. Please contact our Privacy Officer for a fee and/or for an explanation of our fee structure.

Amendment: You have the right to amend your healthcare information, if you feel it is inaccurate or incomplete. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances, your request may be denied.

Non-routine Disclosures: You have the right to receive a list of non-routine disclosures we have made of your health care information. (When we make a routine disclosure of your information to a professional for treatment and/or payment purposes, we do not keep a record of routine disclosures: therefore these are not available.) You have the right to a list of instances in which we, or our business associates, disclosed information for reasons *other than* treatment, payment or healthcare operations. You can request non-routine disclosures going back 6 years starting on April 14, 2003. Information prior to that date would not have to be released. *(Example: If you request information on May 15, 2004, the disclosure period would start on April 14, 2003 up to May 15, 2004. Disclosures prior to April 14, 2003 do not have to be made available.)*

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We do not have to agree to these additional restrictions, but if we do, we will abide by our agreement. (Except in emergencies.) Please contact our Privacy Officer if you want to further restrict access to your health care information. This request must be submitted in writing.

QUESTIONS AND COMPLAINTS

You have the right to file a complaint with us if you feel we have not complied with our Privacy Policies. Your complaint should be directed to our Privacy Officer. If you feel we may have violated your privacy rights, or if you disagree with a decision we made regarding your access to your health information, you can complain to us. In writing. Request a Complaint Form from our Privacy Officer. We support your right to the privacy of your information and will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

HOW TO CONTACT US

Practice Name: VISTA DENTAL

Privacy Officer: DR. BEN TRUONG

Telephone: 702-464-3000 Fax: 702-386-0360

E-Mail: vistadentalvegas@gmail.com

Address: 3960 W. Craig Rd Suite 110 N. Las Vegas, NV 89032

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

_____

Please print your name here

_____

Signature

_____

Date

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- ☐ The patient refused to sign.
- ☐ Due to an emergency situation it was not possible to obtain an acknowledgement.
- ☐ We weren't able to communicate with the patient.
- ☐ Other *(Please provide specific details)*

_____

_____

_____

_____ _____

Employee signature *Date*