STONEWATER DENTISTRY

4450 N. TENAYA WAY SUITE#225 LAS VEGAS NV, 89129

Patient Information Email Address_____

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐ Male ☐ Female

Name:_____ I Prefer to be called: _____

Address:_____**Apt/Unit**:_____City:_____State:_____Zip_____

Phone (_____)_____ Work Phone (_____)_____Cell Phone (_____)_____

The best time to contact me is:_____ ☐ A.M. ☐ P.M. On my: ☐ Home phone ☐ Work phone ☐ Cell phone

Date of Birth:_____ Social Security Number:_____

Spouse or Parent's Name:_____ Their Employer _____Work Phone_____

Person to contact in case of emergency_____ Phone_____

Responsible Party (only fill out if patient being seen is MINOR or you are legal guardian of adult patient; if not just mark "self")

Name: _____SSN#_____ **Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other**

Address: _____ City_____ State_____ Zip_____

Phone: (____) _____Employer_____Work Phone (____) _____

(DENTAL) Insurance Information (Medical insurance information is not needed)

Name of Insured _____DOB_____ SSN#:_____

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other

Name of Employer:_____ Work Phone: (____)_____

Address of Employer:_____City_____State:_____Zip _____

Insurance Company_____ Group #_____ ID#_____

Ins Co Address:_____ Ins Co. Phone:_____

---------- DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ Yes ☐ No IF YES, COMPLETE THE FOLLOWING ----------

Name of Insured_____DOB_____Relationship to Patient _____

SSN#:_____ Name of Employer:_____ __Work Phone: (____)_____

Address of Employer:_____City_____State:_____Zip _____

Insurance Company_____ Group #_____ ID#_____

Ins Co Address:_____ Ins Co. Phone:_____

Referral Information

Whom may we thank for referring you to our practice?

Dental office___ Yellow Pages___ Review Journal___ Val-Pak___ Money Mailer___ School___ Work___ Online___

Banner___ Snap On Smile___ Dental Office___ New Line Smile_____ Other_____

Name of person referring you to our practice_____

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Health Information

Reason for today's visit: _____

Toothache? Where? _____ For how long? _____ Is pain constant? Yes/No Awake at night? Yes/No
(area of the mouth)

Please circle all that apply:

Loose/Mobility Pain/Pressure Broken Tooth Lost Filling Bleeding Gums Swelling Sensitivity: Hot/Cold/Sweet Fever

Other: _____

Date of Last Dental Visit: _____ How often do you floss? _____

How often do you brush your teeth:_____ Do your gums ever bleed? ☐ Yes ☐ No

Do you have any **removable** partials or dentures? Yes/No If Yes How old? _____

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetic
☐ Other If yes, please explain: _____

Have you ever had any of the following? Please check those that apply:

☐ Aids	☐ Excessive Bleeding	☐ Liver Disease	☐ Stroke
☐ Allergies_____ _____	☐ Fainting	☐ Mental Disorders	☐ Tuberculosis
	☐ Glaucoma	☐ Nervous Disorders	☐ Tumors
☐ Anemia	☐ Growths	☐ Pacemaker	☐ Ulcers
☐ Arthritis	☐ Hay Fever	☐ Pregnancy **(currently)**	☐ Venereal Disease
☐ Artificial Joints	☐ Head Injuries	Due Date: _____	☐ HIV
☐ Asthma	☐ Heart Disease	☐ Radiation Treatment	☐ OTHER:
☐ Blood Disease	☐ Heart Murmur	☐ Respiratory Problems	☐ _____
☐ Cancer **(currently)**	☐ Hepatitis	☐ Rheumatic Fever	☐ _____

*If you had cancer but no longer have it; how long have you been cancer free: _____?

☐ Diabetes	☐ High Blood Pressure	☐ Rheumatism
☐ Dizziness	☐ Jaundice	☐ Sinus Problems
☐ Epilepsy	☐ Kidney Disease	☐ Stomach Problems

Have you ever had any serious illness not listed above? ☐ Yes ☐ No If yes, please explain_____
_____

Do You Smoke or Chew Tobacco? ☐ Yes ☐ No

Are you taking any medications, pills, or drugs? ☐ Yes ☐ No
If yes please list:_____

Have you ever had any complications following dental treatment? ☐ Yes ☐ No
If yes, please explain:_____

Have you been admitted to a hospital or needed emergency care during the **past two years**? ☐ Yes ☐ No (no need to list childbirth)
If yes, please explain:_____

Are you **currently** under the care of a physician for an ongoing condition? ☐ Yes ☐ No
If yes, please explain:_____

Do you have any health problems that need further clarification? ☐ Yes ☐ No
If yes, please explain:_____

To the best of my knowledge, the questions on my form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patients) health. It is my responsibility to inform the dental office of any changes in medical status.

_____ **Date**_____
Signature of patient, parent or guardian

OFFICE POLICIES

INSURANCE

As a courtesy to our clients, we will be happy to submit your dental insurance claims on your behalf. However, filing your dental claim is not a guarantee of payment for the services performed. We do not know in advance how much your insurance company will pay until the actual claim is submitted and processed. Many plans have exclusions and limitations which may affect your out-of-pocket expense. We do not match your level of care to insurance plan limitations or benefits. Our staff will be happy to assist you in obtaining maximum dental insurance benefits as well as will try to verify the coverage that your particular plan provides. Ultimately it is your responsibility to know the limitations of your dental plan. Co-pays and deductibles are due at the time service are rendered. If reimbursement by your dental insurance plan provider is not received within 90 days from the date of service, the entire balance is due by you; you may dispute the claim for reimbursement on your behalf directly with your insurance provider. Payment is expected by Stonewater Dentistry within 30 days of the sent invoice statement. Payments not received within this timeframe will be referred to collection. **I understand that my treatment plan is ONLY an "ESTIMATE" of coverage and NOT a guarantee of payment. Any charges not paid by my insurance are my responsibility.**

COPAY- For Major care that requires more than an hour of an appointment time we collect 1/3 portion of the copayment when we reserve the spot for your dental work. That might include an appointment for a crown, root canal, veneer, implant, or more than 4 fillings at a time.

UPGRADES POLICY

Insurance does not cover upgrades for all ceramic crowns. Because insurance companies limit coverage to porcelain fused to base metal crowns, there is an additional fee for upgrading to these types of crowns. Additionally, since insurance companies limit coverage to metal-based partials, there is an additional fee for upgrading to resin-based partials. Some insurance policies exclude coverage for composite (white resin) fillings. At Stonewater Dentistry, we do not utilize amalgam (silver fillings) in our restoration process. This difference in coverage is the responsibility of the patient. Stonewater Dentistry will not be aware of this difference in coverage until payment is received from your insurance carrier. Our team member will call you regarding the balance on your account and we will also send you a statement.

APPOINTMENT CONFIRMATION/ CANCELLATION / MISSED POLICY

ALL APPOINTMENTS MUST BE CONFIRMED. Our office provides text and/or confirmation calls. We ask that if we text or call you that you contact us back as soon as possible to confirm your appointment. Failure to do so may result in your appointment being rescheduled or canceled. Last-minute cancellations deny other patients the benefit of the treatment they require. We would appreciate as much notice as possible**; at least 24 hours for weekday appointments** and **48 hours for Saturday appointments** should a change in appointment be necessary. We do understand, occasionally, an emergency may present itself, whereby you may not be able to provide us with adequate notice. **Patients who are unable to provide 24-hour notice for weekday appointments may be assessed a fee of $25.00 and for Saturday appointments the fee is $50.** Stonewater Dentistry reserves the right to discharge any patient due to missed appointments.

DOUBLE INSURANCE COVERAGE

While having insurance from more than one company may result in a reduction of your out-of-pocket co-pay from your primary provider, **there is no guarantee that charges will be paid in full by both insurance carriers.**

You are still responsible for your co-pay amounts.

I understand the above statements. I will ask any questions I have before services being rendered.

_____ _____

Patient or Guardian Signature **Date:**

_____ _____

Office staff signature **Date:**

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Summary:
By law, we are required to provide you with our notice of privacy practices (NPP). This notice describes how your medical information may be used and disclosed by us. It also tells you how you can obtain access to this information.

As a patient, you have the following rights:

1. The right to inspect and copy your information.
2. The right to request corrections to your information
3. The right to request that your information be restricted.
4. The right to request confidential communications.
5. The right to a report of disclosures of your information.
6. The right to a paper copy of this notice.

We want to assure that your medical/ protected health information is secure with us. This notice contains information about how we will insure that your information remains private.

If you have any questions about this notice, the name and phone number of our contact person are listed on this page.

Contact Person: Sarika Patel, D.M.D Phone Number: 702-734-5000

Acknowledgment of Notice of Privacy Practices

"I hereby acknowledge that I have received a copy of the practices NOTICE OF PRIVACY PRACTICES. I understand that if I have questions, or complaints regarding my privacy rights, that I may contact the person listed above. I further understand that the practice will offer me updates to the NOTICE OF PRIVACY PRACTICES should it be amended, modified, or changed in any way.

_____
Patient or Representative Name (Please Print)

_____ _____
Patient or Representative Signature Date

Patient refused to sign _____

Patient was unable to sign because_____

Consent for Oral Cancer Screening

Our practice continually looks for advances to ensure that we are providing the optimum level or oral health care to our patients. We are concerned about oral cancer and look for it in every patient with a standard exam with every check up.

One American dies every hour from oral cancer. Late detection of oral cancer is the primary cause that both incidence and mortality rates of oral cancer continue to increase. As with most cancers, age is the primary risk factor. Tobacco and/or alcohol use are other major predisposing risk factors but more than 25% of oral cancer victims have no such lifestyle risk factors. Oral cancer risk profile is as follows:

- Increase risk: Patient's ages 18-39 (sexually active- HPV 16/18)
- High Risk: Patient's age 40+ with tobacco use
- High Risk: Patient's age 40+ with lifestyle risk factors tobacco and/or alcohol use with previous history of cancer or family history of cancer.

We have incorporated ***Identafi*** into our oral screening standard of care. We find that using ***Identafi*** along with a standard oral cancer examination improves the ability to indentify suspicious areas at their earliest stages. ***Identafi*** is similar to early detections procedures such as a mammography, PAP smear and PSA to detect other cancers. It is simple and painless examination that gives the best chance to find any oral abnormalities at the earliest possible stages. Early detection of precancerous tissue can minimize or eliminate the potentially disfiguring effects of oral cancer and possibly save your life.

The exam will be offered to you annually and the **fee is $30.00**

_____ **YES**; I would like to have the ***Identafi*** exam along with the standard oral cancer screening that is done with my check up**. I accept financial responsibility for this additional examination.**

_____ **No**, I would prefer to not have the ***Identafi*** exam at this time.

Please Print Patient Name: _____

Patient Signature: _____

STONEWATER DENTISTRY

Smile Questionnaire

Use this questionnaire to help determine your feelings about your smile.

1. What bothers you the most about your smile?

   Explain: _____

2. Are there any spaces that you do not like? Yes/No
   Is there a need for more spaces? Yes /No
   Is crowding a problem? Yes/No
   Explain:_____

3. (Look for esthetic problems)Ask yourself: "Does that (chip, stain, etc.) bother me?'' Yes/No

   Explain:_____

4: Do you like the shape of your teeth? Yes/No

   Explain:_____

5: Do you like the way your bottom teeth and top teeth fit together? Yes/No

   Explain:_____

6: Do you have any discolored or old fillings that bother you or that you don't like seeing when you smile? Yes/No

   Explain:_____

7. Are your teeth as bright as you would like? Yes/No

   Explain:_____

8. How would you like your smile to look?

   Explain:_____

9. How do you rate your smile on a scale of 1-10, with 10 being the best smile? : _____

   Explain:_____

Signature_____ Date_____