ANTHEM PERIODONTICS AND DENTAL IMPLANTS

ED DeANDRADE D.D.S.

DIPLOMATE OF THE AMERICAN BOARD OF PERIODONTOLOGY

W E L C O M E

Patient Information

Date:

Patient Name:

Home Address:

Mailing Address:

Mail Address 2:

City State Zip

Sex: M F Age_____ Birthdate_____

Single___Married_____ Widowed___Separated_____ Divorced_____

Patients SS#:

Occupation:

Employer:

Employer Phone:

Spouse's Name:

Spouse's Employer:

Spouse's Employer Phone:

Whom may we thank for referring you?

Patient Responsibility (If Dependent)

Who is responsible for this account?

Relationship to Patient:

Birthdate: SS#:

Dental Insurance

Insurance Company:

Member ID #

Group ID #

Is patient covered by additional insurance? Yes_____No _____

If yes, Insurance Co:

Member ID #

Group #:

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr. De Andrade all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature Date

PHONE NUMBERS

Home: _____ Work:_____ Ext:___ Cell:_____ Spouse's Work:_____ May we text you? YES/ NO

E-mail: _____ Spouse Email: _____

Best time and place to reach you? _____

IN CASE OF EMERGENCY, CONTACT (Please specify someone who does not live in your household)

Name: _____ Relationship: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _

DENTAL HISTORY

Reason for today's visit:

General Dentist:

City/ State:

Date of last dental visit:

Date of last dental x-rays:

How often do you brush?

How often do you floss?

Place a mark on "Yes" or "No" to indicate if you have or had any of the following:

Bad Breath	☐	Yes	☐	No	Lip or Cheek Biting	☐	Yes	☐	No
Bleeding Gums	☐	Yes	☐	No	Loose teeth or broken fillings	☐	Yes	☐	No
Blisters on lips or mouth	☐	Yes	☐	No	Mouth Breathing	☐	Yes	☐	No
Burning sensation on tongue	☐	Yes	☐	No	Mouth pain, brushing	☐	Yes	☐	No
Chew on one side of mouth	☐	Yes	☐	No	Orthodontic treatment	☐	Yes	☐	No
Cigarette, pipe, or cigar smoking	☐	Yes	☐	No	Periodontal treatment	☐	Yes	☐	No
Clicking or popping jaw	☐	Yes	☐	No	Sensitivity to cold	☐	Yes	☐	No
Dry mouth	☐	Yes	☐	No	Sensitivity to heat	☐	Yes	☐	No
Dark teeth	☐	Yes	☐	No	Sensitivity to sweets	☐	Yes	☐	No
Fingernail biting	☐	Yes	☐	No	Sensitivity when biting	☐	Yes	☐	No
Food collection between teeth	☐	Yes	☐	No	Sores or growths in your mouth	☐	Yes	☐	No
Grinding teeth	☐	Yes	☐	No	Unsightly teeth	☐	Yes	☐	No
Gums swollen or tender	☐	Yes	☐	No	Bad Taste	☐	Yes	☐	No
Jaw pain or tiredness	☐	Yes	☐	No	Any Other Important Issues:				

If you had a magic wand, what would you change about your teeth? _____

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HEALTH HISTORY

Patient's Name: _____ Date of last visit to Physician: _____

Physician's Name: _____ Physician's Phone Number: _____

Physician's Cross Streets: _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS ____Yes ____No
Anemia ____Yes ____No
Arthritis, Rheumatism ____Yes ____No
Artificial Joints ____Yes ____No
Asthma ____Yes ____No
Back Problems ____Yes ____No
Bleeding Abnormally, with extractions or surgery ____Yes ____No
Blood Disease ____Yes ____No
Cancer – (Type:_____) ____Yes ____No
Chemical Dependency ____Yes ____No
Chemotherapy ____Yes ____No
Cortisone Treatments ____Yes ____No
Cough, persistent or bloody ____Yes ____No
Diabetes ____Yes ____No
Drug Use (Illegal) ____Yes ____No
Emphysema ____Yes ____No
Epilepsy ____Yes ____No
Fainting or Dizziness ____Yes ____No
Glaucoma ____Yes ____No
Headaches ____Yes ____No
Hepatitis – (Type:_____) ____Yes ____No
Herpes ____Yes ____No

HIV Positive ____Yes ____No
Jaundice ____Yes ____No
Jaw Pain ____Yes ____No
Kidney Disease ____Yes ____No
Liver Disease ____Yes ____No
Nervous Problems ____Yes ____No
Prosthetic Replacement ____Yes ____No
Psychiatric Care ____Yes ____No
Radiation Treatment ____Yes ____No
Respiratory Disease ____Yes ____No
Rheumatic Fever ____Yes ____No
Scarlet Fever ____Yes ____No
Shortness of Breath ____Yes ____No
Sinus Trouble ____Yes ____No
Skin Rash ____Yes ____No
Swelling of Feet or Ankles ____Yes ____No
Swollen Neck Glands ____Yes ____No
Thyroid Problems ____Yes ____No
Tuberculosis ____Yes ____No
Tumor/Growth on Head or Neck ____Yes ____No
Ulcer ____Yes ____No
Venereal Disease ____Yes ____No
Weight Loss, unexplained ____Yes ____No

Heart Related:
Artificial Heart Valves ____Yes ____No
Circulatory Problems ____Yes ____No
Congenital Heart Lesions ____Yes ____No
Heart Murmur ____Yes ____No
High Blood Pressure ____Yes ____No
Low Blood Pressure ____Yes ____No
Mitral Valve Prolapse ____Yes ____No
Pacemaker ____Yes ____No
Stroke ____Yes ____No

Other: _____ ____Yes ____No
Other: _____ ____Yes ____No
Other: _____ ____Yes ____No
Other: _____ ____Yes ____No
Other: _____ ____Yes ____No
Other: _____ ____Yes ____No
Other: _____ ____Yes ____No

Women:
Are you pregnant? ____Yes ____No
Due Date: _____
Are you nursing? ____Yes ____No

MEDICATIONS

List any and all medications you are currently taking:

_____
_____
_____
_____
_____

Pharmacy Name: _____
Pharmacy Phone: _____
Pharmacy Cross Streets: _____

ALLERGIES (Check all that apply.)

☐ Aspirin
☐ Barbiturates (Sleeping Pills)
☐ Codeine
☐ Iodine
☐ Latex
☐ Local Anesthetic
☐ Penicillin
☐ Sulfa
☐ No Known Allergies

Other Drugs: _____

I consent to treatment as necessary or desirable to the care of the patient first named above, including but not limited to whatever drugs, medicine, performance of operations, and conduct of laboratory, x-ray, or other studies that may be used by the attending doctor or qualified designate. I also acknowledge full responsibility for the payment of such services and agree to pay them in full at the time of service. I acknowledge that it i s my responsibility and not an insurance company to pay for any or all services. Any outstanding balance after 30 days may incur a finance charge of 18% per annum or 1 - 1/2% per month.

Responsible Party's Printed Name (must be 18 years or older)

Responsible Party's Signature (must be 18 years or older)

Date

Doctor's Printed Name

Doctor's Signature

Date

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY

*** * YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT * ***

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

Patient's Printed Name	*Responsible Party's Printed Name (must be 18 years or older)*
Patient's Signature	*Responsible Party's Signature (must be 18 years or older)*
Date	*Date*

Who, in addition to yourself, do we have your authorization to contact or speak with regarding your treatment?
We will only release information to those you have identified here.

Name	*Phone Number*	*Relationship to you*
Name	*Phone Number*	*Relationship to you*

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

We attempted to obtain written Acknowledgement of Receipt of Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barrier prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify): _____

Employee's Printed Name	*Date*
Employee's Signature	

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 April 14, 2003, and will remain in effect until we replace it. We reserve the right to change our privacy practices and the terms of this our notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in 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 may 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 dentist o r other healthcare provider providing treatment to you. Payments: 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 including quality healthcare professionals eval uating practitioner and provider performance, conducting training programs, accreditation, certification, or credentialing activities.

Your Authorization: in addition to the 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 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 written authorization, we cannot use or disclose your health information for any reason except those described in this Not ice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of th is 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 me mber, your personal representative or another person responsible for your care or 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 x-rays or other similar forms of health information.

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.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances, We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities, We may disclose to correctional institution or law enforcement official having lawful custody of patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards or letters)

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use t he format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, heal thcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable cost-based fee for responding to these additional requests. Restrictions: You have the right to request that we place additional restriction s on care or disclosure of your health information. We are not required to agree on these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communications: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. You must make your request in writing. Your request must specify the alternative means, or location, and provide satisfactory explanation how payment will be handled under the alternative means or locations you request. Amendment: You have the right to request that we amend your health information; your request must be written, and it must explain why th e information should be amended. We may deny your request under certain circumstances.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us as follows. Anthem Periodontics and Dental Implants, Compliance Officer, 2610 W. Horizon Ridge Pkwy Suite 202, Henderson, NV 89052 If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health in formation or in response to a request you made to amend or restrict the use or disclosures of your health information, or to have us communicate with you by alternative means or at alternative location, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services.

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FINANCIAL RESPONSIBILITY ACKNOWLEDGEMENT

Dear Patient:

Thank you for choosing **Anthem Periodontics & Dental Implants** as your health care provider. We appreciate the opportunity to assist you with your dental needs. We believe that having financial matters clear from the onset is preferable to encountering difficulties later.

Our financial policy is as follows:

1. Payments are due **upon arrival** for all non-surgical appointments that have a fee.
2. Payments for surgical services are due **2 weeks prior to services rendered**, please refer to surgery cancelation policy form.
3. We accept cash, check, ATM cards, and all major credit cards for your convenience.
4. We will bill your secondary insurance as a courtesy to you, but we will only bill them **once**.
5. If your insurance company does not pay your claim within 30 days, we ask that you contact your insurance company. If your insurance company does not pay in full within 60 days, we require you to pay the balance due with cash, check, or credit card.
6. **All charges are your responsibility, whether your insurance company pays or not. You are responsible for knowing what is covered and what is not covered by your insurance. Not all services are covered by insurance; some insurance companies select certain services that they do not cover. Payment for the services that are not covered by your insurance is due when treatment is rendered.**
7. It is your responsibility to verify that the doctor you are seeing is a provider for your insurance.
8. **A fee of 35% of unpaid balances will be charged to all accounts referred to collections, plus any and all collection fees.**
9. A returned check will be subject to a $25.00 returned check fee.
10. **Forty-eight (48) hours' notice** is required for cancellations to avoid a broken appointment fee of **$50.00 per hour**.

I have read and understand the above policies 1-10.

Responsible Party's Signature (Must be 18 years or older)	Employee's Printed Name
Responsible Party's Signature (Must be 18 years or older)	Employee's Signature
Date:	Date:

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INSURANCE BENEFIT ACKNOWLEDGEMENT

_____ I understand that I am solely responsible for payment of the total treatment fee.

_____I understand that an estimated insurance benefit has been used to calculate my out of pocket expenses.

_____ I understand that Anthem Periodontics and Dental Implants cannot guarantee payment bythe insurance company.

_____In the event that the insurance company pays less than the estimated amount, I agree to pay the difference in full.

_____I understand that if I change insurance companies while in treatment I may owe more.

_____I agree to let Anthem Periodontics and Dental Implants know about any changes in my insurance during treatment.

I hereby certify that I have read and understand the terms of this contract.

Signature Print Name Date

WEBSITE AND SOCIAL MEDIA RELEASE FORM

I hereby grant permission to Anthem Periodontics & Dental Implants, their assigns, licensees, and legal representatives the irrevocable right to use my or my child's story, photographs, radiographs, and other images ("Materials") for publicity, educational, and/or promotional purposes.

I waive any right to inspect or approve any "Materials" to be used. I waive any right to inspect or approve the finished product(s) that may be created and/or posted to Anthem Periodontics & Dental Implants' website, social media outlets, or other mediums in connection therewith.

I hereby release Anthem Periodontics & Dental Implants, their assigns, licensees, and legal representatives from all claims and demands arising out of or in connection with any use of said "Materials", including, without limitation, all claims for invasion of privacy, infringement of my right of publicity, defamation, and any other personal and/or property rights.

I acknowledge and agree that no payment or remuneration or fee of whatsoever nature will be due to me as a result of the use and/or publication or utilization of the "Materials" and waive any rights therein.

☐ Yes, I agree.
☐ No, I decline.

Patient's Printed Name	*Responsible Party's Printed Name (must be 18 years or older)*
Patient's Signature	*Responsible Party's Signature (must be 18 years or older)*
Date	*Date*