

Welcome . . .

Thank you for selecting our dental team! We will strive to provide you with the best possible dental care. To help us meet all of your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us - we will be happy to help.

Dr. Ronald R. Marshall D.D.S., Ltd. 6891 W. Charleston Blvd., Las Vegas, NV 89117 (702)255-6768

Patient Information (CONFIDENTIAL)

Date _____

SS# _____

Name _____ Nickname _____ Birthdate _____

Address _____ City _____ State _____ Zip _____

Phone _____ Alternate Phone _____ Email _____

Check Appropriate Box Minor Single Married Divorced Widowed Separated

Patient or Guardian's Employer _____ Occupation _____ Phone _____

Spouse Name _____ Employer _____ Phone _____

If Patient is a Minor, Guardian's Name _____ Phone _____

Name of Person Responsible for this Account _____ Relationship to Patient _____

Whom may we thank for referring you? Patient/Doctor _____ Insurance List

If you found our office online, which website led you here? Yelp Healthgrades RateMDs Other

Person to Contact in Case of Emergency _____ Phone _____

Dental Insurance Information (we will need a copy of your driver's license and dental insurance card)

Name of Insured _____ Relationship to Patient _____

Birthdate _____ SS# _____ Employer _____

Insurance Company _____ Group # _____ Policy/ID # _____

Ins. Co. Address _____ City _____ State _____ Zip _____

Ins. Co. Phone Number _____

DO YOU HAVE ANY ADDITIONAL DENTAL INSURANCE? Yes No If yes, please complete the following:

Name of Insured _____ Relationship to Patient _____

Birthdate _____ SS# _____ Employer _____

Insurance Company _____ Group # _____ Policy/ID # _____

Ins. Co. Address _____ City _____ State _____ Zip _____

Ins. Co. Phone Number _____

CONTINUE ON BACKSIDE

Patient Medical History

Physician _____ Office Phone _____ Date of Last Exam _____

Yes No

Are you under medical treatment now? Yes No

Have you ever been hospitalized for any surgical operation or serious illness within the last 5 yrs? Yes No

If yes, please explain _____

Are you taking any medication(s) including non-prescription medicine? Yes No

Please list: _____

Have you ever been told that you needed to pre-medicate before any dental appointments? Yes No

If yes, with what medication? _____

Do you use tobacco? Yes No

Do you have or have you had any of the following:

	Yes	No		Yes	No		Yes	No
Abnormal Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Fainting Spells	<input type="checkbox"/>	<input type="checkbox"/>	Colitis	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Pins/Joints/Valves	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
Frequent Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell Disease	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Heart Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Venereal Disease	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Breathing	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Congenital Heart Defect	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Treatment	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>	Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>
Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	HIV / AIDS	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Shingles	<input type="checkbox"/>	<input type="checkbox"/>
Sinus Problems	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>	Fever Blisters	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol/Drug Abuse	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____		
Blood Transfusion	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	_____		

Are you allergic to or have you had any reactions to the following:

	Yes	No		Yes	No
Local Anesthetics	<input type="checkbox"/>	<input type="checkbox"/>	Aspirin	<input type="checkbox"/>	<input type="checkbox"/>
Penicillin	<input type="checkbox"/>	<input type="checkbox"/>	Latex	<input type="checkbox"/>	<input type="checkbox"/>
Erythromycin	<input type="checkbox"/>	<input type="checkbox"/>	Metals	<input type="checkbox"/>	<input type="checkbox"/>
Sulfa	<input type="checkbox"/>	<input type="checkbox"/>	Nuts	<input type="checkbox"/>	<input type="checkbox"/>
Codeine	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____		

WOMEN ONLY:

	Yes	No
a) Are you pregnant or think you may be pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
b) Are you nursing?	<input type="checkbox"/>	<input type="checkbox"/>
c) Are you taking birth control?	<input type="checkbox"/>	<input type="checkbox"/>

Patient Dental History

Name of Previous Dentist and Location _____ Last Visit Date _____

Do you have or have you previously had any of the following:

- | | | |
|---|--|--|
| <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Loose teeth | <input type="checkbox"/> Sensitivity to sweet, hot, cold, biting |
| <input type="checkbox"/> Chronic bad breath | <input type="checkbox"/> Orthodontic treatment | <input type="checkbox"/> Sores, growths or swelling in mouth |
| <input type="checkbox"/> Decayed teeth | <input type="checkbox"/> Periodontal treatment | <input type="checkbox"/> Injury to teeth or jaw |
| <input type="checkbox"/> Grinding or clenching of teeth | <input type="checkbox"/> Food catching between teeth | <input type="checkbox"/> Painful or locking jaw |

Do you like your smile? Yes No

I certify that the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

X _____ Date _____
Signature of Patient (or Parent/Guardian if minor)

OUR OFFICE POLICIES

Welcome to Dr. Ronald Marshall's Family Dentistry. It is our pleasure to have you as our patient. Our commitment is to provide you with the best dental care and to keep you informed of treatment recommendations and financial obligations. The following outlines our office policies. **Please initial on each line that you have read and understand each policy:**

General Policy

- _____ **Payment is due at the time services are rendered.** We accept cash, checks and all major credit cards. We also work in partnership with CareCredit to finance monthly payments (approval process).
- _____ Any outstanding balances are due within 30 days of insurance benefit payment being received. Outstanding balances over 60 days are subject to a 5% interest rate charge per month. Accounts over 90 days will be subject to collections.
- _____ A \$25 returned check fee will be assessed to all returned check accounts, and no future checks can be received as payment.

Insurance Policy

- _____ **It is your responsibility to know your insurance benefits, including your remaining maximum and deductible.** Due to pending claims and/or patient privacy issues, we are not always aware of dental treatment you received outside of our office. If treatment was rendered by another office, please let us know, as it does affect your annual maximum, deductible and/or frequency limits.
- _____ Our office will gladly submit your insurance claim to your insurance carrier, as a courtesy to you. At the time of treatment, the patient/guarantor is responsible for the estimated portion that the insurance does not cover. We are more than happy to verify your insurance benefits prior to scheduling treatment and/or submit pre-authorizations to your insurance company.
- _____ Any benefits not paid by your insurance company within 60 days of services being rendered will become your responsibility. We are more than willing to issue you a credit check if your insurance does end up paying after the allotted time.
- _____ Please understand that you or your employer negotiated your insurance contract, not Dr. Marshall or his employees. If you have a dispute regarding your insurance benefits, please inform your broker or employer.

Missed Appointment Policy

- _____ **As a courtesy to you, we will make every effort to confirm your reserved appointment time, but please do not consider it our responsibility to do so.** If our attempts are unsuccessful, it is still your responsibility to keep your reserved appointment or contact us **24 hours in advance** to change or cancel your appointment.
- _____ **All patients who fail to arrive for their reserved appointments or who cancel without a 24 hour notice will be charged a fee of \$50 PER HOUR of your reserved time.** Please note that this missed appointment fee will not be covered by any insurance plans and will be your responsibility. Any outstanding missed appointment charges must be paid before we can schedule any future appointments. The fee shall be waived only for unforeseen circumstances at Dr. Marshall's discretion.
- _____ If missed appointments become habitual, Dr. Marshall and his staff reserve the right to refuse re-appointment.

I have read, understand and agree to the terms and conditions of these Office Policies.

Signature: _____ Date: _____

CONSENT FOR TREATMENT

I, the undersigned, hereby authorize the doctor and/or his staff to recommended dental services including but not limited to radiographs, examinations, study models, photographs or any other diagnostic aids he/she may deem appropriate to make a thorough diagnosis of my dental needs. I understand that Dr. Marshall's office requires that all radiographs (x-rays) be current within the last 12 months in order to diagnose accurately.

I authorize the doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I authorize and consent that the doctor may employ any such assistance as he deems appropriate.

I fully understand that there are inherent risks involved in the administration of any drug, medicament, antibiotic, or local anesthetic. I fully understand that there are inherent risks involved in any dental treatment which I may have completed in this office.

The most common risks can include, but are not limited to: Bleeding, swelling, bruising, discomfort, stiff jaw, infection, aspiration, nerve disturbance or damage, adverse drug response, allergic reaction, and cardiac arrest.

I realize it is mandatory that I follow any instruction given by the dentist and his associates and take any medications as directed.

I understand that during treatment it may be necessary to change and/or add procedures to my treatment plan because of conditions found while working on the teeth not discovered during examination. I give my permission to Dr. Marshall and his staff to make any changes and additions as necessary.

Alternative treatment options, including no treatment, will be discussed with me in detail. No guarantees will be made to me as to the results of treatment. A full explanation of all complications is available upon request.

Signature of Patient or Guardian

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. THE PRIVACY OF YOUR HEALTH IS IMPORTANT TO US.

OUR LEGAL DUTY:

We are required by 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.

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. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

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 report a disclosure of your information; and
6. The right to a paper copy 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 any quality assessment and improvement activities, reviewing healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: You may give us written authorization to use your health information or to disclose it to anyone for any purpose.

To Your Family, Friends or Caretaker: 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. In the event of incapacity or an emergency situation, we will disclose health information based on a determination using our professional judgment disclosing only information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience to make reasonable inferences of your best interest in allowing a person to pick up x-rays or other similar forms of health information.

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

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

Acknowledgement of Notice of Privacy Practices

*I hereby acknowledge that I have received a copy of this practice's **NOTICE OF PRIVACY PRACTICES**. I understand that the practice will offer me updates to this **NOTICE OF PRIVACY PRACTICES** should it be amended, modified, or changed in any way.*

Patient or Representative Name (Please Print) Representative's Relationship to Patient _____

X _____
Patient or Representative Signature Date _____

Patient Refused to Sign