# 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 ☐ Dr.Oogle ☐ 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 _____

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

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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? | ☐ | ☐ |
| Have you ever been hospitalized for any surgical operation or serious illness within the last 5 yrs? | ☐ | ☐ |
| If yes, please explain _____ | | |
| Are you taking any medication(s) including non-prescription medicine? | ☐ | ☐ |
| Please list: _____ | | |
| _____ | | |
| Have you ever been told that you needed to pre-medicate before any dental appointments? | ☐ | ☐ |
| If yes, with what medication? _____ | | |
| Do you use tobacco? | ☐ | ☐ |

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

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

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

| | Yes | No | | Yes | No |
|---|---|---|---|---|---|
| Local Anesthetics | ☐ | ☐ | Aspirin | ☐ | ☐ |
| Penicillin | ☐ | ☐ | Latex | ☐ | ☐ |
| Erythromycin | ☐ | ☐ | Metals | ☐ | ☐ |
| Sulfa | ☐ | ☐ | Nuts | ☐ | ☐ |
| Codeine | ☐ | ☐ | Other: _____ | | |

**WOMEN ONLY:**

| | Yes | No |
|---|---|---|
| a) Are you pregnant or think you may be pregnant? | ☐ | ☐ |
| b) Are you nursing? | ☐ | ☐ |
| c) Are you taking birth control? | ☐ | ☐ |

# *Patient Dental History*

Name of Previous Dentist and Location _____ Last Visit Date _____

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

- ☐ Bleeding gums
- ☐ Chronic bad breath
- ☐ Decayed teeth
- ☐ Grinding or clenching of teeth
- ☐ Loose teeth
- ☐ Orthodontic treatment
- ☐ Periodontal treatment
- ☐ Food catching between teeth
- ☐ Sensitivity to sweet, hot, cold, biting
- ☐ Sores, growths or swelling in mouth
- ☐ Injury to teeth or jaw
- ☐ 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

for the Dental Office of:
Ronald R. Marshall D.D.S., Ltd.
6891 W. Charleston Blvd.
Las Vegas, NV 89117

**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.**

### *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.

You will be asked to sign an authorization/acknowledgement form when you receive this Notice of Privacy Practices. If you do not sign our authorization/acknowledgement form or you revoke it, as a general rule, we cannot in any manner use or disclose to anyone (excluding you, but including insurance companies and other healthcare providers) your personal health information or any other information in your health record. By law, we are unable to submit claims to payers under assignment of benefits without your signature on our authorization/acknowledgement form. You will however be able to bill your own insurance company for services you wish to pay for "out of pocket." We will not condition treatment on you signing an authorization/ acknowledgement, but we may be forced to decline you as a new patient or discontinue you as an active patient if you choose not to sign the authorization/acknowledgement or revoke it.

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. We may coordinate healthcare treatment or consult with other doctors about your care. We may delegate tasks to ancillary staff involving your treatment or call in prescriptions to your pharmacy on your behalf.
- **Payment:** We may use and disclose your health information to bill or collect payment from you, an insurance company, a health benefits plan or another third party.
- **Healthcare Operations:** We may use and disclose your health information to run our office, assess the quality of care our patients receive and provide you with customer service. We may contact you regarding upcoming appointments, we may call you by name from the waiting room, we may ask you to put your name on a sign-in sheet, or we may review your health information to evaluate staff performance.
- **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, text messages or email messages.)
- **Required by Law:** We may use or disclose your health information when we are required to do so by law.

# PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we may not be allowed to process your insurance claims.

Date: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this dental office. A copy of this signed, dated document shall be as effective as the original.
**MY SIGNATURE WILL ALSO SERVE AS A PERSONAL RECORDS DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTORS/FACILITIES IN THE FUTURE.**

_____ _____

Please ***print*** name of Patient Please ***sign*** for Patient / Guardian of Patient

_____ _____

Legal Representative / Guardian Relationship of Legal Representative / Guardian

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA:
☐ First Name ONLY ☐ Proper Surname ☐ Other _____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

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I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

☐ Cell Phone Confirmation ☐ Text Message to my Cell Phone ☐ Home Phone Confirmation
☐ Work Phone Confirmation ☐ **Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

☐ Cell Phone Confirmation ☐ Text Message to my Cell Phone ☐ Home Phone Confirmation
☐ Work Phone Confirmation ☐ **Any of the Above**

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**Office Use Only**

As a Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgment but did not because:

The patient refused to sign _____
The patient was unable to sign _____
I could not communicate with the patient _____ Signature of Privacy Officer: _____