WELCOME

Date ____________________ Patient Name __________________________ Name You Prefer_____________________
Physical Address ____ Home Phone _____________________
City _____________________________ State _____ Zip Code _____________ Work Phone ______________________
Mailing Address ____ Cell Phone ______________________
City ______________________________ State _____________________________________ Zip Code _____________
Married_____ Single_____ Email Address____
Gender _____________ Age _________ Birthdate _____________ Patient SS # _________________________
Occupation _______________________________________ Employer ____
Employer Address ____ Employer Phone ____________________________
Spouse Name _________________________________ Birthdate ______________ SS# ____________________________
Occupation _________________________________ Spouse's Employer ____

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IN CASE OF EMERGENCY PLEASE CONTACT (someone not living with you)
Name ____ Relationship to you __________________________
Address and Phone Number of Emergency Contact Person ____
Whom may we thank for referring you? ____
Who is responsible for this account? ____ Relationship to patient _____________

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Insurance Company ____ Group # __________
Is patient covered by additional insurance? Yes__ No__ Subscriber's name ____
Subscriber's Birthdate _______________ Subscriber's SS# ________________________ Relationship to Patient ___________
Insurance company _____________________________Subscriber ID#_____________________ Group # __________________
ASSIGNMENT AND RELEASE
I, the undersigned certify that I (or my dependent) have insurance coverage with _____________________________________ and assign directly to doctor 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 Relationship Date

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DENTAL HISTORY

Reason for today's visit ____
Former Dentist ____________________________________ City/State ____
Date of last dental visit _________________________________ Date of last dental X-rays _______________________________
Please check Yes or No to indicate if you have had any of the following:

Bad breath Yes__ No__
Burning sensation on tongue Yes__ No__
Clicking or popping Jaw Yes__ No__
Do you or have you ever experienced pain/discomfort in your jaw joint Yes__ No__
Food collection Yes__ No__
Periodontal Yes__ No__
Loose teeth or broken fillings Yes __ No__
Pain around ear Yes__ No__
Sensitivity to heat Yes__ No__
Sores or growths in your mouth Yes __ No__

Bleeding gums Yes__ No__
Chew on one side of mouth Yes__ No__
Dry mouth Yes__ No__
Food collection between teeth
Foreign objects Yes__ No__
Jaw pain or tiredness Yes__ No__
Mouth breathing Yes__ No__
Sensitivity to cold treatment Yes __ No__
Sensitivity to sweets Yes __No__
How often do you floss ____________
How often do you brush?___________
Botox/Derma-fill (ever had done) Yes ___No___(Interested in treatment) Yes___

Blisters on lips or mouth Yes__ No__
Cigarette, pipe or cigar smoking Yes__ No__
Fingernail biting Yes__ No__
Chewing tobacco Yes__ No__
Grinding teeth Yes__ No__
Lip or cheek biting Yes__ No__
Orthodontic treatment Yes__ No__
Gums swollen Yes__ No__
Sensitivity when biting Yes__ No__
Do you like your smile Yes__ No__
Type of bristles Hard___ Medium___ Soft_____
Have you ever had a serious or difficult problem associated with previous dental work Yes___ No___

MEDICAL HISTORY

Physician's Name _____ **Date of last visit** _____

Please circle or check yes or no to indicate if you have had any of the following:

Epilepsy Yes__ No__ Anemia Yes __No

Fainting or dizziness Yes __ No__ Radiation Treatment Yes__ No__

Arthritis, Rheumatism	**Yes__ No__**	**Glaucoma**	**Yes__ No__**	**Respiratory Disease**	**Yes__ No__**
		Headaches	**Yes__ No__**	**Rheumatic Fever**	**Yes__ No__**
Artificial heart valves	**Yes__ No__**	**Heart Murmur**	**Yes__ No__**	**Scarlet Fever**	**Yes__ No__**
		Heart Problems	**Yes__ No__**	**Shortness of Breath**	**Yes__ No__**
		Hepatitis	**Yes__ No__**	**Sinus Trouble**	**Yes__ No__**
Asthma	**Yes__ No__**	**Type** _____		**Skin Rash**	**Yes__ No__**
Back Problems	**Yes__ No__**	**Herpes**	**Yes __ No__**	**Special Diet**	**Yes__ No__**
Bleeding abnormally (with extractions or surgery)	**Yes__ No__**	**High Blood Pressure**	**Yes__ No__**	**Stroke**	**Yes__ No__**
		Meds: _____		**Swelling of Feet or ankles**	**Yes__ No__**
	Yes__ No__	**HIV Positive**	**Yes__ No__**		
Blood Disease	**Yes__ No__**	**Jaundice**	**Yes__ No__**	**Swollen Neck Glands**	**Yes__ No__**
Cancer	**Yes__ No__**	**Jaw Pain**	**Yes__ No__**	**Thyroid Problems**	**Yes__ No__**
Chemical dependency	**Yes__ No__**	**Joint replacement**	**Yes __ No__**	**Tonsillitis**	**Yes__ No__**
Chemotherapy	**Yes__ No__**	**Kidney Disease**	**Yes__ No__**	**Tuberculosis**	**Yes__ No__**
Circulatory problems	**Yes__No__**	**Liver Disease**	**Yes__ No__**	**Tumor or growth on Head or Neck**	**Yes__ No__**
		Low Blood Pressure	**Yes__ No__**		
Congenital Heart Lesions	**Yes__No__**	**Mitral Valve Prolapse**	**Yes__ No__**	**Ulcer**	**Yes__ No__**
		Nervous Problems	**Yes__ No__**	**Venereal Disease**	**Yes__ No__**
		Pacemaker	**Yes__ No__**	**Weight Loss, unexplained**	**Yes__No__**
Cortisone treatments	**Yes__ No__**	**WOMEN**			
Cough, Persistent or bloody	**Yes__ No__**	**Are you pregnant?**	**Yes__ No__**	**Any hospital stays**	**Yes__No__**
		Due date _____		**Explain** _____	
Diabetes	**Yes__ No__**	**Are you nursing?**	**Yes__ No__**	_____	
Do you wear Contact lenses	**Yes__ No__**	**Are you taking birth control pills?**	**Yes__ No__**	_____	

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MEDICATIONS

Please list medications you are currently taking:
(We can make a copy of your med list)

_____
_____
_____
_____

Pharmacy Name _____
Phone _____

ALLERGIES

___Aspirin
___Barbiturates (sleeping pills)
___Codeine
___Iodine
___Latex
___Local Anesthetic
___Penicillin
___Sulfa
Other _____
_____
_____

I give permission for my dentist and clinical team to take any necessary radiographs, study models, and photographs to make a complete diagnosis of my dental needs. I also give permission for my dentist and dental team to use my photographs for in-office patient education.

I consent to the use and disclosure of my protected health information to obtain payment information in connection with my dental claims.

_____ _____

Patient's Signature **Date**

_____ _____

Doctor's Signature **Date**

(I have read, agree to, and understand the statements listed above)

Jeffrey Stokes DDS

AUTHORIZATION AND RELEASE

I authorize the dentist to release any information including diagnosis and the records of any treatment or examination rendered to my child or myself during the period of such dental care to third party payers and/or other health practitioners.

I authorize and request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me.

I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

CONSENT

1. The undersigned hereby authorizes doctor to take x-rays, study models, photographs of any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of the patient's dental needs.
2. I also authorized doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that doctor chooses and amply such assistance as deemed fit to provide recommended treatment.
3. I understand that all responsibility for payment for dental services provided in this office for my dependents or myself is mine, due and payable at the time of services are rendered unless other arrangements have been made. In the event payments are not received by the agreed upon dates. I understand that a $25 collection charge may be added to my account.
4. I understand that it is my responsibility to advise the dental office of any changes in the information contained on this form.

Patient name: _____ Date: _____

Parent or Responsible Party: _____ Relationship to Patient: _____

Jeffrey Stokes D.D.S.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgment

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

_____

Please Print Name

_____

Signature

_____

Date

_____

For Office use Only

_____

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

___ Individual refused to sign

___ Communications barriers prohibited us from obtaining acknowledgment

___ An emergency situation prevented us from obtaining acknowledgement

___ Other (Please Specify)

_____

_____

JEFFREY STOKES DDS
53 East Lake Mead Pkwy
Henderson, NV 89015
(702) 566-4133

Thank you for choosing Jeffrey Stokes DDS to meet all of your Dentistry needs. We are committed to providing you with quality and affordable dental care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have developed this payment policy.

PAYMENT POLICY

1. **Insurance.** We participate in most PPO insurance plans. If you are not insured by a plan we do business with, payment is due in full at each visit. If you are insured by a plan that we do contract with but don't have an up-to-date insurance card or information, payment in full for each visit is required until we can verify your coverage. **Knowing your insurance benefits is your responsibility.** Please contact your insurance company with any questions you may have regarding your coverage.

2. **Proof of Insurance.** All patients must submit a completed copy of our patient information from before seeing the provider. We will need a copy of your driver's license and current valid insurance card.

3. **Co-payment and deductibles.** All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered insurance fraud.

4. **Non-covered services.** Please be aware that some- and perhaps all- of the services you receive may be considered non-covered benefits by your insurance company, or may not be considered reasonable and customary by insurers. **Ultimately all charges for services rendered are the responsibility of the patient or guarantor.**

5. **Claims Submission.** We will submit your claims to your insurance company **as a courtesy to you.** We will assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information to them directly. It is your responsibility to comply with their request. **Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your Insurance benefit is a contract between you and your insurance company; we are not subject to that contract.**

6. **Coverage changes.** If your insurance changes, please notify us before your next visit so that we can make the appropriate changes to help you receive your maximum benefits. **If your insurance company does not pay your claim in 90 days, the balance will automatically be billed to you.**

7. **Nonpayment.** If your account is **6 months past due, it will be placed with a collection agency.** Once placed in collections, all fees incurred in collecting the debt, including any legal fees, will be added to the patient balance, and become the responsibility of the patient or Guarantor. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, you and your immediate family members may be discharged from this practice. If this were to occur, you will be notified by regular and certified mail that you have 30 days to find alternative dental care.

8. **Missed appointments.** After three no show appointments, you may be dismissed from the practice. Please help us to serve you better by keeping your regularly scheduled appointment. **Any patient who does not show up for his/her appointment and does not call 24 hours in advance to cancel may be billed a $25 no show fee.** Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary for our area.

If you have any additional questions please refer to the **Fair Debt Collection Practices Act. (FairDebtCollection.com)**

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

Sincerely,

Jeffrey Stokes DDS