Christensen Dental

10521 Jeffreys Street, Suite 200, Henderson, NV 89052
(702) 331-2121 www.christensendental.com

Patient Registration

Patient

Name_____ Nickname _____
Home Phone_____ Cell Phone_____ Work Phone_____
Email Address _____
Date of Birth _____ Social Security Number_____
Address_____ City, State & Zip _____
Marital Status ☐ Single ☐Married ☐Widowed ☐Separated ☐Divorced
Previous Address_____
Employer_____Position/Title_____
Employer Address_____

Spouse or Legal Guardian

Name_____
Home Phone_____ Cell Phone_____ Work Phone_____
Date of Birth _____ Social Security Number_____
Address_____
Employer_____Position/Title_____
Employer Address _____

Referred by

Person Name _____
Circle all that apply:
Insurance list / Google / www.christensendental.com
Face Book / Instagram / Yelp

Emergency Contact

Name _____
Phone _____
Address _____
Relationship _____

Primary Insurance

Name of Policyholder/Insured _____
Insurance Company Name _____
Insurance Company Address _____
Insurance Company Phone Number _____
Employer Name _____
Group or Policy Number _____

Secondary Insurance

Name of Policyholder/Insured _____
Insurance Company Name _____
Insurance Company Address _____
Insurance Company Phone Number _____
Employer Name _____
Group or Policy Number _____

Patient Name _____ Date of Birth _____

_____
Patient or legal guardian – please print

_____ _____
Signature Date

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Health History

Patient Name_____

Date of Birth _____

Are you in good health?	Yes	No
Have there been any changes in your health in the past year? If yes, explain.	Yes	No
Have you ever had a serious illness? If yes, explain.	Yes	No
Have you had an operation or been hospitalized in the past 5 years? If yes, explain.	Yes	No
Are you taking or have you recently taken any prescriptions or over-the-counter medications? If yes, include them on the **Medication List** form.	Yes	No
Heart Problems:		
Congenital heart disease, congenital heart failure, heart attack, heart defects, heart murmurs, angina? If yes, explain.	Yes	No
Are you taking aspirin daily?	Yes	No
Mitral valve prolapse?	Yes	No
Pacemaker?	Yes	No
Rheumatic fever?	Yes	No
Stroke or hardening of arteries?	Yes	No
Artificial (prosthetic) heart valve?	Yes	No
Previous infective endocarditis?	Yes	No
Damaged valves in transplanted heart?	Yes	No
High blood pressure?	Yes	No
Low blood pressure?	Yes	No
Abnormal bleeding, anemia, hemophilia?	Yes	No
Other?	Yes	No

Joint Replacements:		
Do you have or have you ever had an orthopedic total joint replacement (hip, knee, elbow, finger, shoulder, etc.)? If yes, which joint? Replacement date:	Yes	No
Allergies:		
Local anesthesia? Epinephrine? Other anesthetics?	Yes	No
Aspirin?	Yes	No
Penicillin, sulfa drugs or other antibiotics?	Yes	No
Barbiturates, sedatives, sleeping pills?	Yes	No
Codeine, other pain meds, narcotics?	Yes	No
Metals?	Yes	No
Latex (rubber)?	Yes	No
Iodine?	Yes	No
Hay fever, seasonal allergies?	Yes	No
Food?	Yes	No
Other?	Yes	No
Other Medical Conditions:		
Arthritis?	Yes	No
Osteoporosis? Medication—IV, injection or oral? Time frame?	Yes	No
Diabetes I or II? A1c?	Yes	No
Asthma, COPD?	Yes	No
Thyroid problems?	Yes	No
Epilepsy?	Yes	No
Mental health disorders? Type?	Yes	No
Recurrent infections?	Yes	No
Kidney problems?	Yes	No

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Other Medical Conditions (continued):	
Do you have Tuberculosis or have you ever been exposed to Tuberculosis?	Yes No
Hepatitis?	Yes No
HIV or AIDS? CD4 or CD4+T-cell count?	Yes No
Do you have a persistent cough that has lasted more than 3 weeks?	Yes No
Do you use tobacco, marijuana or e-cigarettes? Currently or in the past?	Yes No
Oral Cancer?	Yes No
Cancer, radiation, chemotherapy?	Yes No
Other?	Yes No
Women Only:	
Are you pregnant? If so, how many weeks?	Yes No
Are you taking birth control pills or hormonal replacement?	Yes No

Dental Related Issues:	
Do your gums bleed?	Yes No
Are your teeth sensitive?	Yes No
Have you had any problems associated with previous dental treatment?	Yes No
Are you currently experiencing dental pain or discomfort?	Yes No
What is the reason for today's visit?	
How do you feel about your smile?	

Patient Name_____ Date of Birth _____

_____
Patient or legal guardian – please print

Signature _____ Date _____

Patient Update Signature _____ Date _____

Patient Update Signature _____ Date _____

Patient Update Signature _____ Date _____

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Medication List

Patient Name_____ Date of Birth _____

Name of Medication	Dosage	Amount Taken Per Day

_____

Patient or legal guardian – please print

_____ _____

Signature Date

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General Dental Consent Statement

I hereby authorize and request the performance of dental services for myself or for:

Patient Name_____ Date of Birth _____

I also give my consent to ANY advisable and necessary dental procedures, medications or anesthetics to be administered by the attending dentist or his supervised staff for diagnostic purposes or dental treatment. These may include study models, photographs, X-rays and blood studies.

I understand and acknowledge that I am financially responsible for the services provided for myself or the above named, regardless of insurance coverage. Treatment plans involving extended credit circumstances are subject to a credit check. I also understand that the treatment estimate presented to me is only an estimate. Occasionally, the need may arise to modify treatment. In such a case, I will be informed of the need for additional treatment and its fee modifications.

_____

Patient or legal guardian – please print

_____ _____

Signature Date

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Notice of Privacy Practices and Acknowledgement

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 1, 2018, and will remain in effect until we replace it.

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. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all 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. 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 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 our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our 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 an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosure permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this 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 member, your personal representative or other person responsible for your care, of your location, your general condition or death. If you are present, then prior to use of 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 filled prescriptions, medical supplies, x-rays or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

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 protected health information of an inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voice mail messages, postcards, letters, emails or text messages--standard rates may apply).

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 the 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. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies,

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there may be a charge to you which includes time to locate, doctor verification, and copy your health information, export, then print or email photos and/or radiographs, and postage if you want the copies mailed to you.

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, healthcare operations and certain other activities, for the last 5 years, but not before March 31, 2013. 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.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: 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 payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our website or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

Returned Check/Insufficient Funds: For declined payments, a $30.00 declined payment fee is billed to the responsible party. This action may be reported to the Nevada State Check Fraud Commission and further penalties may apply.

Records Retention: The health care records of a person who is 23 years of age and older may be destroyed after 7 years or for any longer period provided by federal law. For persons less than 23 years of age, records may not be destroyed until they have reached age 23. After they reach age 23, records can be destroyed if they have been retained for 7 years or for any longer period of time provided by federal law.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us. 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 information or in response to a request you made to amend or restrict the use of disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, 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 upon request. We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Tyler M. Christensen, 10521 Jeffreys Street, Suite 200, Henderson, NV 89052.
Phone 702-331-2121 or FAX 702-331-1616.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign this Acknowledgement

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

_____ _____
Signature Date

I authorized _____ access to all dental and financial information until otherwise notified.

I have chosen not to sign this acknowledgement. _____ (please initial)

For Office Use Only

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

☐ Individual refused to sign
☐ Communications barriers prohibited obtaining the acknowledgement
☐ An emergency situation prevented us from obtaining acknowledgement
☐ Other (please specify): _____

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Financial Policy

Thank you for choosing us for your dental needs. We are committed to providing you with excellent care and convenient financial options. We realize you may be requiring some dental care, and it is easy to forget that a doctor's office is also a small business. In the interest of both good medicine and good business, we believe it is best to communicate our financial policy to avoid any misunderstandings later.

PAYMENT:
Payment for service is due at the time services are provided unless **other payment arrangements** have been approved in advance. We accept CASH, CHECK, BANK DEBIT, VISA, MASTERCARD, AMERICAN EXPRESS and DISCOVER. You might also be interested in taking advantage of one of our financing options, available through a third-party finance company (CareCredit). They offer a variety of INTEREST FREE financing, including 6-month and 12-month options (if you qualify).

INSURANCE:
We will be happy to process your insurance claim form, as a courtesy to you. If you have insurance, please be prepared to pay your portion of the total treatment fee on the day of service. Please understand that insurance policies vary greatly, therefore, we can only estimate your coverage in GOOD FAITH. We cannot guarantee coverage due to the complexities of insurance contracts. As a service to our patients, we will bill insurance carriers on your behalf for the services performed in our office. We will allow them 45 days to render payment. After 60 days, you are responsible for the remaining balance in full. Remember, YOUR dental insurance is **a contract between you, your employer and the insurance company**. We are not a party to that contract. If you have any questions about insurance information or are uncertain regarding coverage, we may be able to help. However, in some cases it may be best to contact your insurance company directly.

MISSED OR CANCELLED APPOINTMENTS:
If you are unable to keep your scheduled appointment, please have the courtesy of calling and cancelling your appointment. By doing so, we will have the opportunity to fit another person into our schedule. You understand that you are liable for a **$50.00 non-cancellation fee** if your appointment is not cancelled **24 hours** prior to the scheduled time.

SERVICE CHARGES:
The policy of this office is to charge 1.5% interest monthly (18% annual percentage rate) or a billing charge which is applied to all accounts over 60 days past due. Also, if your account should be sent to a collection agency, you agree to pay reasonable collection fees, attorney fees and court costs incurred in the collection of your overdue account. There will be a $30.00 charge for all returned checks.

You agree we may contact you by telephone, text or email at any number or email address associated with your account, including wireless telephone numbers which could result in charges to you.

I UNDERSTAND AND AGREE TO THIS FINANCIAL POLICY.

Patient Name_____ Date of Birth _____

_____
Person responsible for account – please print

_____ _____
Signature Date