

**Patient Information**

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name _____
First Name _____ Middle Initial _____

Address _____

E-mail _____

City _____

State _____ Zip _____

Sex ☐ M ☐ F Age _____

Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Patient Employer/School _____

Occupation _____

Employer/School Address _____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

**Dental Insurance**

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to _____
Name of Insurance Company(ies)

Dr. _____ 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 authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature of Patient, Parent, Guardian or Personal Representative

Please print name of Patient, Parent, Guardian or Personal Representative

Date Relationship to Patient

**Phone Numbers**

Home (_____) _____ Work (_____) _____ Ext _____ Alt. Phone (_____) _____

Spouse's Work (_____) _____ Best time and place to reach you _____

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

Name _____ Relationship _____

Phone (_____) _____ Alt. Phone (_____) _____

**Dental History**

Reason for today's visit _____	Burning sensation on tongue ☐ Yes ☐ No	Mouth breathing ☐ Yes ☐ No
_____	Chew on one side of mouth ☐ Yes ☐ No	Mouth pain, brushing ☐ Yes ☐ No
Former Dentist _____	Cigarette, pipe, or cigar smoking ☐ Yes ☐ No	Orthodontic treatment ☐ Yes ☐ No
City/State _____	Clicking or popping jaw ☐ Yes ☐ No	Pain around ear ☐ Yes ☐ No
Date of last dental visit _____	Dry mouth ☐ Yes ☐ No	Periodontal treatment ☐ Yes ☐ No
Date of last dental X-rays _____	Fingernail biting ☐ Yes ☐ No	Sensitivity to cold ☐ Yes ☐ No
Place a mark on "yes" or "no" to indicate if you have had any of the following:	Food collection between the teeth ☐ Yes ☐ No	Sensitivity to heat ☐ Yes ☐ No
Bad breath ☐ Yes ☐ No	Foreign objects ☐ Yes ☐ No	Sensitivity to sweets ☐ Yes ☐ No
Bleeding gums ☐ Yes ☐ No	Grinding teeth ☐ Yes ☐ No	Sensitivity when biting ☐ Yes ☐ No
Blisters on lips or mouth ☐ Yes ☐ No	Gums swollen or tender ☐ Yes ☐ No	Sores or growths in your mouth ☐ Yes ☐ No
	Jaw pain or tiredness ☐ Yes ☐ No	How often do you floss? _____
	Lip or cheek biting ☐ Yes ☐ No	How often do you brush? _____
	Loose teeth or broken fillings ☐ Yes ☐ No	

Dental Registration and History



Health History

Physician's Name _____ Date of last visit _____

Have you ever used a bisphosphonate medication? Common brand names are Fosamax, Actonel, Atelvia, Didronel, Boniva. ☐ Yes ☐ No

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ☐ Yes ☐ No

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

AIDS/HIV	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No	Respiratory Disease	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Fainting or dizziness	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Arthritis, Rheumatism	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No
Artificial Heart Valves	☐ Yes ☐ No	Headaches	☐ Yes ☐ No	Shortness of Breath	☐ Yes ☐ No
Artificial Joints	☐ Yes ☐ No	Heart Murmur	☐ Yes ☐ No	Sinus Trouble	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Heart Problems	☐ Yes ☐ No	Skin Rash	☐ Yes ☐ No
Back Problems	☐ Yes ☐ No	Hepatitis Type _____	☐ Yes ☐ No	Special Diet	☐ Yes ☐ No
Bleeding abnormally, with extractions or surgery	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Blood Disease	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Swollen Feet or Ankles	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Jaundice	☐ Yes ☐ No	Swollen Neck Glands	☐ Yes ☐ No
Chemical Dependency	☐ Yes ☐ No	Jaw Pain	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No
Chemotherapy	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Circulatory Problems	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Congenital Heart Lesions	☐ Yes ☐ No	Low Blood Pressure	☐ Yes ☐ No	Tumor or growth on head or neck	☐ Yes ☐ No
Cortisone Treatments	☐ Yes ☐ No	Mitral Valve Prolapse	☐ Yes ☐ No	Ulcer	☐ Yes ☐ No
Cough, persistent or bloody	☐ Yes ☐ No	Nervous Problems	☐ Yes ☐ No	Venereal Disease	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No	Weight Loss, unexplained	☐ Yes ☐ No
Emphysema	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No		
Do you wear contact lenses?	☐ Yes ☐ No	Radiation Treatment	☐ Yes ☐ No		

Women:

Are you pregnant? ☐ Yes ☐ No

Due date _____

Are you nursing? ☐ Yes ☐ No

Taking birth control pills? ☐ Yes ☐ No



Medications

List any medications you are currently taking and the correlating diagnosis:

Pharmacy Name _____

Phone (_____) _____



Allergies

☐ Aspirin

☐ Local Anesthetic

☐ Barbiturates (Sleeping pills)

☐ Penicillin

☐ Codeine

☐ Sulfa

☐ Iodine

☐ Other _____

☐ Latex



Updates (To be filled in at future appointments)

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions? _____

Are you taking any new medications? _____ If so, what? _____

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions? _____

Are you taking any new medications? _____ If so, what? _____

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____



Steven L. Hardy DDS

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DENTAL TREATMENT CONSENT FORM

Please read and initial the items checked below

Patient Name _____

WORK TO BE DONE

I understand that I am having the following work done: Fillings _____ Extractions _____ Impacted teeth removed _____ Root Canals _____ FMX/Exam _____ Other _____ (Initials _____)

DRUGS AND MEDICATIONS

I understand that antibiotics and analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction) (Initials _____)

CHANGES IN TREATMENT PLAN

I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to Dr. Hardy to make any/all changes and additions as necessary. (Initials _____)

REMOVAL OF TEETH

Alternatives to removal have been explained to me (root canal therapy, crowns, and periodontal surgery, ect.) and I authorize Dr. Hardy to remove the following teeth _____ and any others necessary for reasons in paragraph #3. I understand that removing teeth does not always remove all the infection, if present, and it may be necessary to have further treatment. I understand the risks involved in having teeth removed, some of which are pain, swelling, spread of infection, dry socket, loss of feeling in my teeth, lips, tongue and surrounding tissue that can last for an indefinite period of time (days or months) or fractured jaw. I understand I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment, the cost of which is my responsibility. (Initials _____)

DENTURES, COMPLETE OR PARTIAL

I realize that full or partial dentures are artificial, constructed of plastic, metal and/or porcelain. The problems of wearing these appliances have been explained to me including looseness, soreness, and possible breakage. I realize the final opportunity to make changes in my new dentures will be the "teeth in wax" try-in visit. I understand that most dentures require relining approximately three to twelve months after initial placement. The cost for this procedure is not included in the initial denture fee. (Initials _____)

PERIODONTAL LOSS (TISSUE AND BONE)

I understand that I have a serious condition, causing gum and bone inflammation or loss and that it can lead to the loss of my teeth. Alternative treatment plans have been explained to me, including gum surgery, replacements and/or extractions. I understand that undertaking any dental procedures may have a future adverse effect on my periodontal condition. (Initials _____)

I understand that dentistry is not an exact science and that, therefore, reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorized. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction. I consent to the proposed treatment.

Signature of Patient _____ Date _____

Signature of Parent/Guardian if patient is a minor _____ Date _____



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DENTAL INSURANCE INFORMATION

Dental insurance is one of the most beneficial and most misunderstood factors in dental treatment today. This explanation will attempt to clear up many common misconceptions about dental insurance.

Dental insurance is a contract between the employer and the patient. It has NO CONNECTION at all to the provider of your dental treatment. The extent of coverage varies greatly from company to company, and sometimes even within a company. It has absolutely nothing to do with the level of service provided by the dentist or the fee charged for these services.

Here at our office, we will diagnose your oral health needs based on just that, your needs. Though we will try to help you maximize your insurance benefits, please understand that most insurance companies are in business because they make money and are not necessarily looking out for the best interest of your health or function. Typically the insurance company pays for the least expensive fix, which may or may not be advantageous for your oral health or situation. With that in mind, a part of Dr. Hardy's examination will include a discussion of treatment options to best meet your wants and needs which may or may not be a benefit of your specific insurance plan.

An often misunderstood term used by many insurance companies is "UCR". This is an arbitrary fee ceiling at which the insurance company will stop reimbursement. After this ceiling, coverage for a particular procedure will cease. Again, this has nothing to do with the fee charged, but with the level of coverage negotiated by your employer.

We will make every effort possible to assist you with your particular insurance coverage. Although it is not required, we will prepare and submit your insurance claim form at no cost as a courtesy for you, our patient. The estimated patient share will be due at time of treatment unless prior arrangements have been made. Should our estimate of patient share be too high, a refund will be made at the time of payment from the insurance company. Likewise, if the estimate was low, the remainder will be due at that time.

If you have any further questions concerning dental insurance, please let us know and we will be happy to discuss them with you.

Signature: _____

Date: _____



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Welcome to Paradise Family Dental, the practice of Steven L. Hardy D.D.S., a leading dental care practice in North Las Vegas, Nevada. We understand the importance of good dental hygiene and oral care and are committed to providing you the best care in a pleasant and relaxing environment. We offer a wide range of dental services including preventive, cosmetic, restorative, and reconstructive dentistry all in one convenient location with one dentist, Dr. Hardy. This is his only office which assures that your dental needs will be met consistently and timely. Using advanced technology, our experienced staff works together as a team to give you exceptional quality treatment from the moment you walk in for your initial visit.

Paradise Family Dental is dedicated to providing quality oral health care and we pride ourselves in being a patient-centered practice. Our goal is to improve the oral health of every individual we treat, which will improve his or her quality of life. We will do everything possible to make dental visits pleasant and relaxing for our patients so everyone leaves with a smile. We will be using the latest materials and equipment to assure quality and ease for our dental procedures and sterilization.

We expect our patients to be courteous, honest, and willing to become a team player in their dental treatment. We want you to understand not only what your treatment is, but why it is so important to your oral health. Through open communication and realistic expectations, pleasing results will be achieved.

In an effort to eliminate the feeling of a "mass clinic" environment, appointment times are specifically scheduled for you and your needed dental treatment. We hope that you will feel the professional yet personal service we are rendering. For this reason, we ask that you please call 24 hours in advance if you need to reschedule your appointment. This allows us the opportunity to provide service to another patient who may be waiting to come in. If we do not have the 24 hour notice, you will be charged a fee of \$30 (unapplied credits to your account will be used).

Initialed _____

If you are bringing children with you that are not being seen for a scheduled appointment, we ask that you please also bring a baby sitter. Children are not to be left unattended in the waiting room and, for safety reasons, we can not have them in the operatories during your treatment. Along those same lines, a minor must have a parent or legal guardian present in the office at all times during their appointment. Parents will be asked to stay in the waiting room during their child's appointment.

Initialed _____

We thank you again for your interest in becoming a patient in our office. If you have any questions, please ask. **Signed** _____ Date _____

Personally providing quality dentistry with integrity and a smile



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HIPAA PRIVACY POLICY

In compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) we must notify you of our privacy policy. This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. An unabridged copy of the privacy statement is available upon request.

We recognize that our relationship with our patients is based on integrity and trust. We work hard to maintain your privacy and are very careful to preserve the private nature of our relationship with you. At the same time, the very nature of our business sometimes requires that we collect or share certain information about you with other health care providers, organizations and companies. We want you to be aware of how we handle personal information and the measures we take to protect it.

We may collect personal information about you from the following sources:

- From you or your authorized representative on forms, in interviews, or by other means;
- From medical, dental, or health care providers, governmental agencies, employers, or others
- From your insurance carriers, their affiliates or others.

To the extent permitted by law, we may disclose the information we collect, as described above, to health care providers, insurance carriers, their party billing agencies, business associates, or other service.

We require anyone to whom we disclose your personal information to protect its confidentiality and to use it solely for the purpose for which it is disclosed.

We restrict access to nonpublic personal information about you to those employees who need to know that information to provide products and services to you. We maintain physical, electronic and procedural safeguards that comply with applicable regulatory standards to guard your nonpublic personal information.

Your rights regarding your health information:

- To ask us to restrict our uses and disclosure practice
- To ask us to communicate with you in a confidential way
- To ask for photocopies of your health information
- To ask us to amend your health information
- To ask us for a list of disclosures that have

We reserve the right to change this notice at any time in compliance with and as allowed by law. It is our intent to protect your nonpublic personal information. If you have questions or would like to register a complaint, please contact our office and ask to speak with Dr. Hardy.

Signature below is only an acknowledgement that you have received this Notice of our Privacy Practice.

Print Name: _____ Signature: _____ Date: _____

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HIPAA CONSENT FORM

In compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I authorized Dr. Steven L. Hardy and his staff to contact me for the purpose of informing me of appointments, recall dates, or other reasons relating to my oral health. I authorize Dr. Hardy or his staff to leave voice or text messages on my home phone, cell phone, work phone, or e-mail if deemed necessary. I also authorize the use of postcards and letters to my home and work addresses if deemed necessary.

I agree to allow Dr. Hardy and his staff to share any information that they deem relevant for the purposes of billing for reimbursement of service provided.

Furthermore, I understand that I am authorizing Dr. Hardy to release information related to my health and oral health care to my primary care physical and/or other health care providers.

I have received and read a copy of Dr. Hardy's Privacy Policy.

I am aware that I may withdraw this authorization at any time with written notification.

Signature (or Parent/Guardian)

Date