Vegas Dental Experts

Harvey H. Chin DDS
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Las Vegas, NV 89118

Patient Information

Today's Date:_____

Patient Name:_____SS#:_____

Address:_____

City:_____ State:_____ Zip:_____

Phone Number:_____ Cell:_____

[] Male [] Female Age:_____ Birthdate:_____ [] Married [] Single [] Widowed [] Other

E-Mail Address:_____

Occupation:_____Employer:_____

Whom may we Thank for your referral?_____

Person to notify in case of Emergency:_____ Phone Number:_____

Person Responsible for Account:_____ Relation to Patient:_____

Address if Different:_____

City:_____ State:_____ Zip:_____

Phone Number: _____ Cell:_____

E-Mail:_____

Insurance

Primary

Name of Insured:_____ Birthdate:_____

SS#/Identification#:_____ Relationship to patient:_____

Name of Insurance:_____ Insurance Phone:_____

Insurance Address:_____

Group #_____ Employer/Group Plan:_____

Secondary if you have additional coverage

Name of Insured:_____ Birthdate:_____

SS#/Identification#:_____ Relationship to patient:_____

Name of Insurance:_____ Insurance Phone:_____

Insurance Address:_____

Group #:_____ Employer/Group Plan:_____

Vegas Dental Experts
General/Medical Information Update

Patient Name:_____ Date:_____

Address Change [] Yes [] No If yes, please update:_____

Any Changes to your Insurance? [] Yes [] No If yes, please update:_____

Medical History

Are you under the care of Doctor at this time [] Yes [] No If yes, Why?_____

Doctors Name:_____ Dr's Phone #:_____
Are you allergic to: (**Please Circle)**

Penicillin Codeine Local Anesthetics Sulfa Aspirin Tranquilizers Latex
Other:_____

Are you taking Medication at this time? Including over the counter and Birth Control? If Yes Please list:_____
_____
_____

Women: Are you Pregnant? [] Yes [] No If yes how far along:_____ Are you Nursing? [] Yes [] No
Have you ever been told or taken an antibiotic before dental treatment? [] Yes [] No If Yes, Why?:_____
_____

Do you have or have you had any of the following **(Please check Yes or No):**

Artificial Heart Valve	[] Yes [] No	Aids/HIV	[] Yes [] No	Anemia	[] Yes [] No
Angina	[] Yes [] No	Arthritis	[] Yes [] No	Asthma	[] Yes [] No
Bisphosphonate Therapy	[] Yes [] No	Cancer	[] Yes [] No	Chemo	[] Yes [] No
Bleeding Problems	[] Yes [] No	Diabetes	[] Yes [] No	Dizzy Spells	[] Yes [] No
Drug Addiction	[] Yes [] No	Emphysema	[] Yes [] No	Epilepsy	[] Yes [] No
Fainting	[] Yes [] No	Glaucoma	[] Yes [] No	Hepatitis	[] Yes [] No
Heart Attack/Surgery	[] Yes [] No	Jaundice	[] Yes [] No	Pacemaker	[] Yes [] No
Heart Murmur/Problems	[] Yes [] No	Joint Replacement	[] Yes [] No	Lung Disease	[] Yes [] No
Kidney Disease	[] Yes [] No	Latex Allergy	[] Yes [] No	Liver Problem	[] Yes [] No
High Blood Pressure	[] Yes [] No	Low Blood Pressure	[] Yes [] No	Sinus Trouble	[] Yes [] No
Psychiatric Care	[] Yes [] No	Rheumatic Fever	[] Yes [] No	Sleep Apnea	[] Yes [] No
Thyroid Problems	[] Yes [] No	Tobacco Use	[] Yes [] No	Stroke	[] Yes [] No
TMD or TMJ	[] Yes [] No	Tuberculosis	[] Yes [] No	Venereal Disease	[] Yes [] No

Are there any other health problems not listed, which we should be aware of? [] Yes [] No If yes, explain _____
_____

To the best of my knowledge, I have answered every question completely and accurately. I will inform Dr Chin of any changes in my health and/or medication. I further certify that I consent to taking x-rays and an oral examination.

_____ _____
Patient/Parent/Guardian Signature Date

_____ _____
Doctors Signature Date

Medical Update

1. _____ _____ _____
Patient/Parent/Guardian Signature Doctors Signature Date

2._____ _____ _____
Patient/Parent/Guardian Signature Doctors Signature Date

3._____ _____ _____
Patient/Parent/Guardian Signature Doctors Signature Date

Financial Policy

We are pleased to offer our patients high quality dental care. As a courtesy to the patient, we will bill your insurance company for you. However, you are **ULTIMATELY** responsible for all charges incurred for your dental treatment. We accept checks, American Express, Visa, MasterCard and Discover, as well as Care Credit. In order to maintain this service, we must insist on the following guidelines:

Insurance

We work with most insurance companies. We estimate the patient's co-pay according to the information we receive from your insurance company. The insurance is only an **ESTIMATE** and that you will be responsible for any balance left after they have paid. A statement for that balance will be sent If there is secondary coverage, we will bill both insurance companies and will again send a statement for any balance left after both have paid and any balance is due upon receipt of statement. If, in the event this balance goes unpaid, 3 statements will be sent along with letters requesting said balance, if after 90 days the balance still remains unpaid, the undersigned/patient agree to pay the fee of up to 40%. In the event of legal recovery of unpaid balance, the undersigned/patient further agrees to pay court cost and attorney fees.

Financing

Co-pay or treatment amount is due at the start of this treatment unless other arrangements have been made and a copy attached to the treatment plan. We are happy to offer patients the convenience of financing through Care Credit, which offers 12 months interest free if qualified. Please ask if you are interested in filling out an application.

No Show Appointments

We require at least a 24 hour notice to cancel appointments. There will be a $50.00 charge for any appointment that is not kept or cancelled with 24 hour notice.

Returned Check

We are happy to take a check as payment, but in the event it is returned to our office the charges will be added back to your account along with a $45.00 fee.

I certify that I have read, understand and agree to the above financial policy

_____ _____

Patient/Parent/Guardian Signature Date

_____ _____

Practice Manager/Treatment Coordinator Date

Acknowledgement of Receipt of Notice of Privacy Practices

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states we may use and/or disclose your health information.

Please sign this form to acknowledge receipt of this notice

I acknowledge that I have received and read a copy of this office's Notice of Privacy Practices

_____ _____

Signature Patient/Parent/Guardian Date

_____

Printed Name

OFFICE USE ONLY

We have made every attempt to obtain written acknowledgement of receipt of our Notice of Privacy Practices from this patient but it could not be obtained because:

[] Patient Refused to sign [] Due to an emergency situation [] We were not able to communicate

[] Other (Please Specify):_____

_____ _____

Employee Signature Date

HIPAA Acknowledgement of Receipt of the Notice of Privacy Practices. This form does not constitute legal advice and covers only federal, not state law