A+ DENTAL GROUP

Patient Information

Patient Name: _____ Date: _____
Last First MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other e-mail: _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ **(Work):** _____ **Ext:** _____ **Cell #** _____

Best time to call: _____ Preferred appointment times: ☐ AM ☐ PM ☐ Evening ☐M ☐T ☐W ☐T ☐F ☐S

Address: _____
Street Apartment #

_____
City State Zip Code

Office policy: I, understand that there will be a $25 cancellation fee charged per patient for any appointments cancelled with less than 24hours notice. We appreciate your understanding.
Initial X _____

Health Information

Please check those that apply:

- ☐ HIV
- ☐ Allergies _____ _____
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ Pregnancy Due date: _____
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Smoking/Tobacco
- ☐
- ☐
- ☐

ALLERGIES: Circle those that apply: Penicillin, Aspirin, Codeine, Iodine, Latex, Anesthetics, Sulfa, NONE
Other Allergies: _____

- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, name of Physician: _____
- List of Medications: _____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ Date: _____
Signature of patient, parent or guardian

Referral Information

Whom may we thank for referring you to our practice? ☐Another patient, friend ☐Another patient, relative

☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other _____

Name of person or office referring you to our practice: _____

Responsible Party Information (Please fill out if patient is under 18 years of age)

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Employment Information

Employer Name: _____ Occupation: _____

Address: _____
Street City State Zip Code

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

Secondary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

Assignment and Release

I certify that I have answered all questions correctly and to the best of my knowledge. I certify that I and/or my dependent(s), have insurance coverage with _____ and assign directly to A Plus Dental Groups and its associates 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 payable for related services.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____
Signature of guarantor of payment/responsible party

A Plus Dental Group

Patient Name_____

Dental Consent Form

- **WORK TO BE DONE**

  I understand that I am having the following work done: Exam and X-rays.

  Initial _____

- **DRUGS AND MEDICATIONS**

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

  Initial_____

- **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 teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the dentist to make any/all changes and additions as necessary.

  Initial_____

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_____ **Relationship**_____ **Date**_____

Patient or legal representative

Doctor_____ Witness_____

A Plus Dental Group

Financial Policy

Thank you for choosing A Plus Dental Group for your dental care. We are committed to providing excellent dental care with convenient financial arrangements. We kindly ask that you read and understand this policy prior to treatment to assure there is full disclosure of payment options and expectations.

If you have Dental Insurance.

- Our office is committed to helping patients maximize their benefits.
- Your dental insurance is a three way contract between you, your employer and your dental insurance provider.
- If we are a contracted provider, which means that we agree to contracted fees and terms that your insurance company has presented to us, we will provide you with a breakdown of explanation of benefits as well as a complete estimate of what your financial responsibility will be.
- There may be a maximum allowed per year, limitations, frequencies and exclusions on your plan.
- There may be a deductible and/or copayment that is due at time of service.
- We do our best to give you the most accurate estimate of your insurance benefits, however, insurance reimbursement is not guaranteed.
- We may bill you any portion of the service that is not paid by your insurance.
- In the event that your account is turned over to a collections agency for non-payment or delinquency, you will be responsible for payment of any collection cost, in addition to the balance owed.

If you do not have Dental Insurance.

- Our in house discount plan is guaranteed competitive and affordable.
- We will explain your treatment options and financial obligations clearly.
- Full payment is expected at time of service unless prior financial arrangement is made.
- We accept Cash, Visa/MC, Discover, AMEX
- We offer prepayment discount and treatment package discount
- We offer financing through CareCredit *(Ask for details)*
- In the event that your account is turned over to a collections agency for non-payment or delinquency, you will be responsible for payment of any collection cost, in addition to the balance owed.

Printed Name of Patient/Responsible Party: _____

Signature of Patient/Responsible Party: _____

Date: _____

Oral Screening Consent Form

Complete each time the examination is performed and place in the patient's file

Our practice continually looks for advances to ensure that we are providing the optimum level of oral health care to our patients. We are concerned about oral cancer and look for it in every patient.

One American dies every hour from oral cancer. Late detection of oral cancer is the primary cause that both the incidence and mortality rates of oral cancer continue to increase. As with most cancers, age is the primary risk factor for oral cancer. Tobacco and alcohol use are other major predisposing risk factors but **more than 25% of oral cancer victims have no such life style risk factors.** Studies also suggest that human papillomavirus (HPV) plays a roll in more than 20% of oral cancer causes. * Oral cancer risk by patient profile as follows:

Increased risk:	patients ages 18-39 -sexually active patients (HPV)
High risk:	patients age 40 and older; tobacco users (ages 18-39, any type within 10 years)
Highest risk:	patients age 40 and older with lifestyle risk factors (tobacco and/or alcohol use); previous history of oral cancer

We have recently incorporated VELscope powered by Sapphire into our oral screening standard of care. We find that using VELscope powered by Sapphire along with a standard oral cancer examination improves the ability to identify suspicious areas at their earliest stages. VELscope Powered by Sapphire, along with the doctor's visual exam, is similar to proven early detection procedures for other cancers such as mammography, Pap smear, and PSA. VELscope powered by Sapphire is a simple and painless examination that gives the best chance to find any abnormalities at the earliest possible stage. Early detection of pre-cancerous tissue can minimize or eliminate the potentially disfiguring effects of oral cancer and possibly save your life. The VELscope powered by Sapphire exam will be offered to you annually.

This enhanced examination is recognized by the American Dental Association code revision committee as CDT-2007/08 procedure code D0431; however, this exam might not be covered by your insurance. The fee for this enhanced examination is $30.00.

☐ Yes. I would prefer to have the VELscope powered by Sapphire exam at this time.

☐ No. I would prefer not to have the VELscope powered by Sapphire exam at this time.

Print Name _____

Signature _____ Date _____

VELscope® powered by Sapphire

A Plus Dental Group

Patient Name: _____ **Date:** _____

DENTAL QUESTIONNAIRE FORM

To better understand your dental needs please fill out this short dental questionnaire form. Please circle yes or no and answer questions as indicated.

1. Do your gums bleed when you brush or floss? Yes No
2. Do you have earaches or neck pains? Yes No
3. Are your teeth sensitive to cold, hot, sweets or pressure? Yes No
4. Do you have any clicking, popping or discomfort in the jaw? Yes No
5. Does food or floss catch between your teeth? Yes No
6. Do you brux or grind your teeth? Yes No
7. Is your mouth dry? Yes No
8. Do you have sores or ulcers in your mouth? Yes No
9. Have you had any periodontal (gum) treatments? Yes No
10. Do you wear dentures or partials? Yes No
11. Have you ever had orthodontic (braces) treatment? Yes No
12. Do you participate in active recreational activities? Yes No
13. Have you had any problems associated with previous dental treatment? Yes No
14. Have you ever had a serious injury to your head or mouth? Yes No
15. Date of your last dental exam_____
16. What was done at that time?_____
    _____
17. Date of last dental x-rays_____
18. Are you currently experiencing dental pain or discomfort? Yes No
19. What is the reason for your dental visit today?_____
    _____
20. How do you feel about your smile?_____
    _____

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.

_____
{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.

Communication barriers prohibited obtaining the acknowledgment.

A emergency situation prevented us from obtaining acknowledgment.

Other (Please Specify)

_____
_____
_____
_____
_____

A Plus Dental Group

Notice of Privacy Practices

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.

The privacy of your health information is important to us.

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 3/1/15, 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 that we maintain, including 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.

You may request a copy of our Notice at any time. 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 dentist, 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 health care 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 disclosures 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. By state law, your authorization is valid for 90 days.

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 you 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 another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or 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 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 authorize 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 inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

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, we may charge you $0.83 for each page up to thirty (30) and $0.63 for each page after thirty, a $19 administrative fee to locate and copy your health information, and postage if you want the copies mailed to you. Radiographs (x-rays) will be duplicated at a reasonable fee. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.

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 6 years, but not before April 14, 2003. 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 a Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

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 or 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.

Privacy Officer:	Kam Khossoosi
Telephone:	(702) 522-9192
Fax:	(702) 546-5679
Address:	2285 E. Flamingo Rd., #101 Las Vegas, NV 89119