Date: ____

Patient's Last Name____________________________________ First Name ________________________________
(MI)_______

Home
Address____
_
Street CITY STATE ZIP
CODE

Patient's SS#_____________-____________-
____

Birth date
_____________________________Age________________

Preferred name (**nickname**)__________________________
____

Home
Phone________________________Cell___________________

Drivers License
#____

Email
Address____

Occupation____
____

Employer____
___

Work
Address____

____
___

Work
Phone____

Spouse's
name____

DENTAL INSURANCE

Has your dental insurance changed? Yes? No?
If yes, please provide us with the following information:

Insurance Co.
#1____
___

Group#

Your current health is? Good? Fair? Poor?

Do you smoke or use tobacco? Yes? No?

Are you presently taking any prescription drugs? Yes? No?
If yes, please
list:____

____
___
____
___

Do you HAVE/HAD any of the following Medical problems?

Y N Heart Attack/Stroke
Y N HIV +/Aids
Y N Shingles
Y N Kidney Problems
Y N Sinus Problems
Y N Endocarditis
Y N Diabetes
Y N Drug/Alcohol Abuse
Y N Respiratory Problems
Y N Joint Replacement
Y N Hemophilia
Y N Heart Murmur
Y N Esophagitis/Reflux
Y N Artificial Heart Valve
Y N Hepatitis A, B, C
Y N Cancer/Chemotherapy
Y N Heart Surgery/Pacemaker
Y N Anemia
Y N (High) (Low) Blood Pressure
Y N Severe Headaches
Y N Psychiatric Problems/ Anxiety
Y N Tuberculosis (TB)
Y N Sickle Cell Disease
Y N Epilepsy/Seizures/Fainting
Y N Rheumatic Fever
Y N Mitral Valve Prolapse
Y N Thyroid Problems
Y N Congenital Heart Defect

List any serious medical conditions since your last visit.

____
____

Have you ever been pre-medicated prior to a dental appointment? Y N

Are you allergic to any of the following?

Y N Penicillin
Y N Dental Anesthetics
Y N Erythromycin
Y N Aspirin
Y N Codeine
Y N Latex

Group#____
___

Do you have other dental insurance coverage? Yes? No?
Other Insurance Co.
#2____
__

Group#____
__

Insured's
Name____

Insured's Date of Birth
____

Insured's Person's SS# ___________--_________--
____

Insured's
Occupation____

Insured's
Employer____

Address____
___

____
__

Phone Number
____

This coverage is through Self? Spouse? Parent? Other?

Who referred you to our office?

____
__

Patients' regular physicians:

____
__

Are you allergic to any other drugs? If yes, please list:

____-
______

____
____

For women, are currently pregnant? Yes? No?

DENTAL HISTORY

Why have you come to the dentist today?

____
____

____
____

Are you currently in pain? Yes? No?

Are you under any stress or anxiety at home or work? Yes No

Do you experience stress when you visit a dental office? Yes No

The approximate date of your last visit? ___________________

Have you ever experienced TMJ problems? Yes No

(TMJ is pain or discomfort in your jaw) joints)

Your current dental health is? Good? Fair? Poor?

Do you grind your teeth? Yes No

Do you like your smile? Yes No

Do your gums ever bleed? Yes No

Would you like to prevent dentures? Yes No

It is the patient/insured responsibility to notify our office of any insurance changes

CANCELLATION POLICY

We keep a cancellation waiting list for those of you who have last minute needs. If you need to cancel or reschedule you appointment, please do so 24 hours prior to your appointment time. If we do not receive this 24-hour notice, a charge may be assessed to your account.

LATE ARRIVALS

One of our office policies is to single book appointments and therefore we take pride in being on schedule as much as possible. With this in mind, we would appreciate you arriving on time for your appointment.

INSURANCE

I agree that it is my responsibility to understand my insurance benefits, deductibles, co-payments, and limitations. Your insurance policy is a contract between you, and your employer and the insurance company. Even though we may be contracted with your insurance company our relationship is with you not your insurance company. All services are provided to you with the understanding that you are responsible for your cost regardless of your insurance company coverage. We will bill the insurance company from the information you have provided to us as a courtesy, but you are still ultimately responsible for payment of any service your receive. The billing department will follow up on your claim by checking with your carrier once verbally and then once in writing. However, if your insurance company does not respond to us within 90 days of claim submission, the amount will become your responsibility and you will have to follow up with your carrier for payment of the claim. I also understand that it is my responsibility to notify this office of any insurance changes. I understand the appropriate treatment will be provided for me, regardless of what my insurance policy and provisions are, and agree to pay any unpaid charges. If it becomes necessary that your account be turned over to collections, you will be responsible for all collection fees, legal fees and court cost. Return checks are subject to a $45.00 fee.

I understand my dental insurance carrier may reduce payment for Resin Restoration on posterior teeth and allow an alternate benefit payment of Amalgam restoration. I agree the difference between the dentist's charge for resin restoration and the amount paid by my insurance carrier is my responsibility. I agree to pay the difference after insurance for cosmetically enhanced procedures.

I understand that the information I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status

CONSENT FOR PURPOSES OF TREATMENT, PAYMENT, & HEALTHCARE OPERATIONS

I consent to the use or disclosure of my protected health information by Bradley Ditsworth, D.M.D. for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Bradley Ditsworth, D.M.D.. I understand that diagnosis or treatment of me by Dr. Ditsworth may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Bradley Ditsworth, D.M.D.. is not required to agree to the restrictions that I may request. However, if agrees to a restriction that I request, the restriction is binding.

I have the right to revoke this consent, in writing, at any time, except to the extent that Dr. Ditsworth or Bradley Ditsworth's office staff has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

Patient Signature ____ **Date**______________________________

Guardian/parent signature ____**Date**______________________________

(If a minor, parent or guardian)

Payment is due in full at the time of treatment unless prior arrangement has been approved.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Purpose of Consent**: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.**

Notice of Privacy Practices**: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.**

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Officer:**__D. Budinger__** E-mail:__drditsworth@aol.com__Telephone:**__(702) 798-6216__**Fax: **__(702) 798-6269__**

Right to Revoke**: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.**

I have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and heath care operations.

Patient Signature ____ **Date**______________________________