NEW PATIENT PACKAGE

We want to welcome you to our practice

We ask you to realize that we don't work for an insurance company.

Rather we work 100% for our patients. We feel that insurance can be a great benefit for many patients and want you to know we will do everything in our power to ensure you get every benefit allotted in your insurance contract. However, the treatment we recommend and the fees we charge will always be based on your individual needs, not your insurance coverage.

To be more efficient and considerate of your time, please:

- Print, Read and Fill out all documents.
- You may also add copy of your driver license & insurance card.
- Fax documents to us at (702)617-0332 or via E-mail at wigwamdental@gmail.com

We are looking forward to seeing you soon

- Like Us on Facebook/ wigwamdentalcare
- Check out our web page for special & promotions
  www.seedentist.com
- Address:
  2649 Wigwam Pkwy #106
  Henderson, NV 89074

Patient Information Form (Confidential)

Today's Date:____/____/2015

First Name: _____

Last Name: _____

Home Phone: (702)_____-_____

Work Phone: (702)_____-_____

Cell Phone: (702)_____-_____

E-mail: _____

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form. If you have any questions or need assistance, please ask us—we will be happy to help.

Patient's Information

Home address:_____

City:_____ State:____ Zip:_____

Date of birth ____/____/_____

Social Security Number _____/____/_____

Driver's License _____ State _____

Single Married Separated Divorced Widowed

Employer:_____

Position:_____

Business address:_____

City:_____ State:____ Zip:_____

Responsible Party Information

(if patient is a responsible party for this account, you can skip this section)

Name:_____

Home address:_____

City:_____ State:_____ Zip:_____

Date of birth ____/____/19____

Social Security Number _____/____/_____

Driver's License _____ State _____

Employer:_____

Position:_____

Business address:_____

City:_____ State:_____ Zip:_____

For your convenience, we offer the following methods of payment.

Please check the option you prefer:

CASH CHECK VISA MasterCard AmericanExpress Debit/ATM Discover

I wish to discuss the office's payment policy

PAYMENT IS EXPECTED IN FULL AT EACH APPOINTMENT

Insurance Information

Insurance company:_____

Group number:_____ Policy number:_____

Insurance company phone number:_____

Effective date of coverage:_____

Name of insured:_____

Relationship to patient:_____

Name of employer:_____

DO YOU HAVE ADDITIONAL INSURANCE?
IF YES, COMPLETE THE FOLLOWING:

(Please note: Failure to disclose insurance information constitutes an insurance fraud, a felony in the State of Nevada. NVCC1349.33)

Secondary Insurance Information

Insurance company:_____

Group number:_____ Policy number:_____

Insurance company phone number:_____

Effective date of coverage:_____

Name of insured:_____

Relationship to patient:_____

Social Security Number:_____/____/_____

Date of birth:____/____/19____

Phone number:_____

Name of employer:_____

Person to contact in case of emergency:

Name:_____ Phone:_____

Whom may we thank for referring you? (check one)

[ ] providers list [ ] insurance co. [ ] yellow pages

[ ] media advertising [ ] internet [ ] drove by

[ ] existing patient _____

Please continue onto the other side >>>>>>>>>>>>>>>>>>>

Patient Medical History

Physician_____Phone_____Date of Last Exam_____

1. Are you under medical treatment now?.....YES NO
2. Have you ever been hospitalized for any surgical operation or serious illness?.....YES NO
   If yes, please explain.....
   .....
3. Are you taking any medication(s) including non-prescription medicine?.....YES NO
   If yes, what medication(s) are you taking?.....
   .....
4. **Women Only:**
   Are you pregnant?.....YES NO
   Do you think you may be pregnant?.....YES NO
   Are you nursing?.....YES NO
   Are you taking oral contraceptives?.....YES NO
5. **Are you allergic to or have you had any reaction to the following?**
   Penicillin or any other Antibiotics.....YES NO
   Local Anesthetics(e.g. Novocaine).....YES NO
   Sulfa Drugs.....YES NO
   Barbiturates.....YES NO
   Sedatives.....YES NO
   Iodine.....YES NO
   Aspirin.....YES NO
   Any Metals (e.g. nickel, mercury, etc).....YES NO
   Latex Rubber.....YES NO
   Other (please list).....YES NO
6. Do you use tobacco?.....YES NO
7. Do you use Controlled substances?.....YES NO

8. Do you have or have you had any of the following?

High Blood Pressure.....YES NO
Heart Attack.....YES NO
Rheumatic Fever.....YES NO
Swollen Ankles.....YES NO
Fainting/Seizures.....YES NO
Asthma.....YES NO
Low Blood Pressure.....YES NO
Epilepsy/Convulsions.....YES NO
Leukemia.....YES NO
Diabetes.....YES NO
Kidney Diseases.....YES NO
AIDS or HIV Infection....YES NO
Thyroid Problem.....YES NO

Heart Disease.....YES NO
Cardiac Pacemaker.....YES NO
Heart Murmur.....YES NO
Angina.....YES NO
Anemia.....YES NO
Emphysema.....YES NO
Cancer.....YES NO
Arthritis.....YES NO
Joint Replacement or Implant.....YES NO
Hepatitis/Jaundice.....YES NO
Sexually Transmitted Disease.....YES NO
Stomach Troubles/Ulcers.....YES NO
Frequently Tired.....YES NO

Chest Pains.....YES NO
Easily Winded.....YES NO
Stroke.....YES NO
Hay Fever/Allergies.....YES NO
Tuberculosis.....YES NO
Radiation Therapy.....YES NO
Glaucoma.....YES NO
Recent Weight Loss.....YES NO
Liver Disease.....YES NO
Heart Trouble.....YES NO
Respiratory Problems.....YES NO
Mitral Valve Prolapse.....YES NO
Other.....YES NO

Patient Dental History

Name of Previous Dentist and Location _____ Date of Last Exam _____

1. Do your gums bleed while brushing or flossing?.....YES NO
2. Are your teeth sensitive to hot or cold liquids/foods?.....YES NO
3. Are your teeth sensitive to sweet or sour liquids/foods?.....YES NO
4. Do you feel pain to any of your teeth?.....YES NO
5. Do you have any sores or lumps in or near your mouth?.....YES NO
6. Have you had any head, neck or jaw injuries?.....YES NO
7. Have you ever experienced any of the following problems in your jaw?
   Clicking.....YES NO
   Pain (joint, ear, side of face).....YES NO
   Difficulty in opening, closing or chewing.....YES NO
8. Do you have frequent headaches?.....YES NO
9. Do you clench or grind your teeth?.....YES NO
10. Do you bite your lips/cheeks frequently?.....YES NO
11. Have you ever had any difficult extractions in the past?.....YES NO
12. Have you ever had any prolonged bleeding following extractions?.....YES NO
13. Have0 you had any orthodontic treatment?.....YES NO
14. Do you wear dentures or partials?.....YES NO
    If yes, date of placement_____
15. Have you ever received oral hygiene instructions regarding teeth and gums.....YES NO
16. Do you like your smile?.....YES NO

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand and agree with a collection service charge of fifty percent of the outstanding balance which will be added once my account becomes delinquent, additional fee of one hundred and fifty dollars will be charged in addition to court fees to cover any small claims court filings.

Signature of patient (or parent if minor) X_____ Date: _____

You May Refuse To Sign This Acknowledgement

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

_____
Print name

_____
Signature

_____
Date

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

__ Communication barriers prohibited obtaining the acknowledgement

__ an emergency situation prevented us from obtaining acknowledgement

__ Other (please specify)

****Don't forget to Check In on Facebook****

_____

WIGWAM DENTAL CARE
2649 Wigwam Parkway Suite 106
Henderson, NV 89074
(702) 617-3333

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW THE HALTH 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 your 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 9/23/13, 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 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 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 your health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use and disclose your health information to a physician or other healthcare providers 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 or disclose your health information in connection with or 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 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.

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 to your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose your 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 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 judgement disclosing only health

information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgement and our experience with common practice to make reasonable interferences of your best interest in allowing a person to pick up filled prescriptions, dental supplies, x-rays, or other similar forms of your health information.

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

Required by Law: When required to do so by law. We may disclose your health information to the appropriate authorities.

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 a 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 correction institutions 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 also request access by sending us a letter to the address at the end of this notice. If you request copies we will NOT charge 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 6 years, but not before April 14, 2003.

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 can abide by our agreement (except in an emergency).

Alternate Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations (you just 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, 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 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 complaining with the U.S. Department Of 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: Sabina Telephone: 617-3333 Fax: 617-0332

Email: Wigwamdental@gmail.com

Address: 2649 Wigwam Parkway Henderson, NV 89074

WIGWAM DENTAL

2649 WIGWAM PARKWAY #106

HENDERSON, NV 89074

I _____, refuse to have my health information disclosed to anyone except those listed in the Notice of Privacy Practices and the list of names I provide.

1. _____
2. _____
3. _____

_____

Signature

_____

Date

For Office Use Only
