A1 Dental Care
7780 S. Jones Blvd Suite 101
Las Vegas, Nevada 89139
(702) 450-6060
www.A1dentalcare.com

CHART # _____
For Office Use Only

REFERRAL INFORMATION

Please mark all that apply

Whom may we thank for referring you?

Family Member_____
Co-Worker_____
Friend_____
Doctor_____
Other _____

Or did you find us on your own?

☐ Our Website ☐ Facebook
☐ Google ☐ Yelp
☐ Banner/Drive By ☐ Mailer/Postcard
☐ Insurance Company ☐ Radio/TV
☐ Other _____

Dental History

When was your last dental exam? _____ Dental cleaning? _____

Are you happy with the appearance of your teeth?	○ Yes	○ No
Are your teeth all in alignment (straight)?	○ Yes	○ No
Do you like the color of your teeth?	○ Yes	○ No
Do you like the shape of your teeth?	○ Yes	○ No
Do you have spaces that you do not like?	○ Yes	○ No
Are your teeth wearing down on the biting surfaces?	○ Yes	○ No
Have old fillings/dental work you don't like looking at?	○ Yes	○ No

Are your teeth ☐ Chipped ☐ Protruding ☐ Hidden

What would you like to change the most about the appearance of your teeth?

How would you like your teeth to look?

Please check the boxes of all that apply:

☐ Pain or discomfort at this time
☐ Clench or grind your teeth
☐ Gums bleed when you brush
☐ Pain in jaw joints
☐ Headaches: If yes, how often _____
☐ Loose teeth
☐ Broken or chipped teeth /fillings
☐ Bad breath
☐ Smoke or use tobacco
☐ Teeth that trap food between them
☐ Teeth sensitive to: ☐ Hot ☐ Cold ☐ Sweets ☐ Biting
☐ Have you ever been treated by: ☐ Orthodontist ☐ Periodontist

Why did you leave your last dentist?

Please list your sports activities and hobbies.

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Medical History and Information

Are you under a physician's care now? ○ Yes ○ No Reason_____

Have you been hospitalized in the past two years? ○ Yes ○ No Reason_____

Are you taking blood thinners? ○ Yes ○ No Medication_____

Are you taking any other drugs or medications? ○ Yes ○ No Reason_____

Have you had a Hip or Knee Replacement? ○ Yes ○ No Which Joint? ☐ Hip ☐ Knee

Have you ever had any of the following? Please check mark those that apply:

Abnormal Bleeding ☐
Alcohol Abuse ☐
Anemia ☐
Angina Pectoris ☐
Arthritis ☐
Artificial Heart Valve ☐
Asthma ☐
Blood Transfusion ☐
Cancer ☐
Chemotherapy/Radiation Therapy ☐
Colitis ☐
Congenital Heart Defect ☐
Cosmetic Surgery ☐
Diabetes ☐
Difficulty Breathing ☐
Drug Abuse ☐
Emphysema ☐
Epilepsy ☐
Fainting Spells ☐
Fever Blisters ☐
Frequent Headaches ☐
Glaucoma ☐
Hay Fever ☐
Heart Attack ☐
Heart Murmur ☐
Heart Surgery ☐
Hemophilia ☐
Hepatitis A ☐
Hepatitis B ☐
Hepatitis C ☐
High Blood Pressure ☐
Hiv + / AIDS ☐
Infectious Endocarditis ☐
Kidney Problems ☐
Liver Disease ☐
Low Blood Disease ☐
Mitral Valve Prolapse ☐
Pace Maker ☐
Pneumocystis ☐
Psychiatric Problems ☐
Rheumatic Fever ☐
Seizures ☐
Shingles ☐
Sickle Cell Disease ☐
Sinus Problems ☐
Stroke ☐
Thyroid Problems ☐
Tuberculosis ☐
Ulcers ☐
Venereal Disease ☐
Yellow Jaundice ☐

Allergies:

Amoxicillin/Penicillin ☐
Aspirin ☐
Codeine ☐
Dental Anesthetics ☐
Erythromycin ☐
Jewelry ☐
Latex ☐
Metals ☐
Sulfa ☐
Tetracycline ☐
Other Allergies:

For Women, Are you: ☐ Taking Birth Control ☐ Pregnant - # of Weeks_____ ☐ Nursing

Do you have or have you had any condition or problem not listed above? ○ Yes ○ No
Explain:

To the best of my knowledge, all the preceding answers are correct. If I have any changes in my health status or if my medicines changes, I will inform the dentist and staff before the next appointment.

SIGNATURE: _____ DATE: _____

FOR OFFICE USE: Reviewed by _____ DATE: _____

MEDICAL UPDATES

I have read my medical history above and confirm that it adequately states past and present conditions.

DATE	CHANGES	SIGNATURE	REVIEWED BY

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Patient Information

Patient Name Last _____First_____ Initial ___ Preferred Name ___

Birth Date_____ Soc. Sec. # _____ ○ Male ○ Female Marital Status: Select

Address _____ Apt. _____City _____State____ Zip Code_____

Phone (Home) _____ (Cell) _____ (Work)_____Ext:_____

E-Mail Address_____ _____Text Message Appointment Reminders ○ Yes ◉ No

Employer _____ Position _____

Employer Address _____ City _____ State ____ Zip _____

Medical Physician_____ Phone Number _____

Previous Dentist_____ Phone Number _____

Parent/Spouse's Name_____Phone_____

Emergency Contact_____Relationship_____Phone_____

Responsible Party Information

The following is for: ○ Parent/Guardian ○ Patient's Spouse ○ Not Applicable-Same as above

Name Last _____First _____Initial ____ Relationship to Patient Select

Birth Date _____ Social Security #_____ Phone _____

Address _____ Apt. ___City _____State____ Zip Code_____

Employer _____ Occupation _____

Primary Dental Insurance Information

Name of Insured _____ Relationship to Patient Select

Insured's Birth Date_____ Social Security #_____ Phone _____

Insurance Co._____ Employer_____

Secondary Insurance Information

Name of Insured _____ Relationship to Patient Select

Insured's Birth Date_____ Social Security #_____ Phone _____

Insurance Co._____ Employer_____

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Acknowledgement of Receipt of Notice of Privacy Practices

Signature below is only acknowledgement that you have received the Notice of our Privacy Practices. You may request a copy of our Notice of Privacy Practices if you would like it in writing:

Print Name: _____ Signature: _____ Date: _____

Please provide the following information if you would like to authorize our office to release your information: (optional)

I, _____, authorize the release of treatment and financial records

pertaining to _____ (patient name) to the following people:

_____Relationship_____

_____Relationship_____

_____Relationship_____

Print Name: _____ Signature: _____ Date: _____

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TO OUR VALUED PATIENT:

Thank you for choosing us as your dental care provider. We are committed to providing you with the best care possible. In order to achieve this goal, we need your assistance and your understanding of our financial policies. If you have any questions or concerns regarding these policies, please feel free to ask any of our staff. If you would like a photocopy of this outline, please ask. Please understand the following:

1. Payment for services is due at the time services are rendered. We accept Cash, Checks, Visa, MasterCard, Discover, American Express, CareCredit, and Springstone Financing. As a courtesy, we will submit an insurance claim on your behalf if you show proof of coverage. If your insurance company/coverage changes, please notify us immediately.

2. DENTAL INSURANCE: Our office will gladly work with you to help get the maximum benefit available to you. Most dental insurance plans do not cover 100% of your cost of treatment. Therefore, you will be expected to pay your deductible and your *estimated* co-payment on the day services are rendered. We will gladly file your insurance claim. Many variables exist from carrier to carrier (i.e. deductibles, annual maximums, allowable fee limitations, non-covered procedures, and other restrictions); therefore, we cannot guarantee any estimated charges. Because your insurance is an agreement between you and the insurance company, ultimately you are responsible for all charges whether the insurance company pays or not. You are responsible for knowing your insurance benefits. Please know that we will do everything possible to see that you receive the full benefits from your insurance company. If for some reason your insurance company has not paid their estimated portion within 60 days from the start of treatment, you are responsible for payment in full at that time. We expect prompt payment from you within 15 days of statement received for any balance due after insurance pays. Treatment could be altered if your dental needs change. The patient will be notified of any change(s) in treatment.

3. Any balance due on account over 120 days without payment arrangements will be turned over to the collection agency representing our office. In the event your account is sent to a collection agency, you will be responsible for any collection fees, legal fees, or court costs.

4. Payment and co-pays for treatment (crowns, bridges, partials, and dentures) are due on the day services are rendered before we begin treatment.

5. Returned checks are subject to a $25 returned check fee.

6. We respectfully ask that you give us a minimum of 24 hours notice to cancel or reschedule your appointment. Please help us serve you better by keeping scheduled appointments. We reserve the right to charge $25 per hour for appointments cancelled or broken without 24 hours advance notice.

7. No minor children (under the age of 18 yrs old) will be treated without a parent present at all times.

8. The VIP referral credit of $25 will only be applicable and applied to your account if the person you are referring brings in a referral card at the time of their first visit with your name on it.

AUTHORIZATION & RELEASE: I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to myself or my dependent during the period of such dental care to third party payers and/or healthcare practitioners. I authorize and request my insurance company to pay directly to the dentist the amount due on my claim for services rendered to myself or my dependent. I understand that my insurance carrier may pay less than the actual bill for service; and if the nature of the liability were such that it is not covered by the policy, I agree to be responsible for payment of all services rendered on my behalf or my dependents.

I agree to have any photos taken of me to be used for education, training, and/or marketing.

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

Select

_____	_____	_____
Signature of Patient, Parent, or Guardian	Date	Relationship to Patient