# ANTHEM PERIODONTICS AND DENTAL IMPLANTS

ED DeANDRADE D.D.S.

DIPLOMATE OF THE AMERICAN BOARD OF PERIODONTOLOGY

WELCOME

## PATIENT INFORMATION

Patient Name: ______________________

Home Address: ______________________

Mailing Address: ______________________

______________________
*City* *State* *Zip*

Sex: M F Age:________ Birth Date:________

(circle one): Single Married Widowed Separated Divorced

Patient SSN: ______________________

Is the patient the responsible party? No Yes

*If no, continue below with the **Responsible Party**'s information.*
*If yes, skip to the Insurance Information.*

Name: ______________________

Home Address: ______________________

Mailing Address: ______________________

______________________
*City* *State* *Zip*

Sex: M F Age:________Birth Date: ________

(circle one): Single Married Widowed Separated Divorced

SSN: ______________________

## DENTAL INSURANCE

Who is responsible for this account? ______________________

Relationship to Patient: ______________________

Insurance Company: ______________________

Group #: ______________________

Employer: ______________________

Is patient covered by additional insurance? Yes No

If yes, Insurance Company: ______________________

Subscriber's Name: ______________________

Group #: ______________________

Birth Date: ____________ SSN: ______________________

Relationship to Patient: ______________________

## ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage with ______________________ and assign directly to Dr. De Andrade 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 hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

______________________
*Responsible Party's Signature* *Date*

## PHONE NUMBERS

Home: ______________ Work: ______________ Cell: ______________

Spouse's Work: ______________________ May we text you? ____________

Best time and place to reach you: ______________________ E-mail: ______________________

## IN CASE OF EMERGENCY, CONTACT (Please specify someone who does not live in your household.)

Name: ______________________ Relationship: ______________________

Home Phone: ______________ Work Phone: ______________ Cell Phone: ______________

## DENTAL HISTORY

Reason for today's visit: ______________________

______________________

General Dentist: ______________________

City/ State: ______________________

Date of last dental visit: ______________________

Date of last dental x-rays: ______________________

How often do you brush? ______________________

How often do you floss? ______________________

*Place a mark on "Yes" or "No" to indicate if you have or had any of the following:*

| Condition | Yes | No | Condition | Yes | No |
|---|---|---|---|---|---|
| Bad breath | ___Yes | ___No | Gums swollen or tender | ___Yes | ___No |
| Bad taste | ___Yes | ___No | Jaw pain or tiredness | ___Yes | ___No |
| Bleeding gums | ___Yes | ___No | Lip or cheek biting | ___Yes | ___No |
| Blisters on lips or mouth | ___Yes | ___No | Loose teeth or broken fillings | ___Yes | ___No |
| Burning sensation on tongue | ___Yes | ___No | Mouth breathing | ___Yes | ___No |
| Chew on one side of mouth | ___Yes | ___No | Mouth pain, brushing | ___Yes | ___No |
| Cigarette, pipe, or cigar smoking | ___Yes | ___No | Orthodontic treatment | ___Yes | ___No |
| Clicking or popping jaw | ___Yes | ___No | Periodontal treatment | ___Yes | ___No |
| Dry mouth | ___Yes | ___No | Sensitivity to cold | ___Yes | ___No |
| Dark teeth | ___Yes | ___No | Sensitivity to heat | ___Yes | ___No |
| Fingernail biting | ___Yes | ___No | Sensitivity to sweets | ___Yes | ___No |
| Food collection between teeth | ___Yes | ___No | Sensitivity when biting | ___Yes | ___No |
| Grinding teeth | ___Yes | ___No | Sores or growths in your mouth | ___Yes | ___No |
| | | | Unsightly teeth | ___Yes | ___No |

If you had a magic wand, what would you change about your teeth? ______________________

DIPLOMATE OF THE AMERICAN BOARD OF PERIODONTOLOGY

# ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY

*** * YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT * ***

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

| | |
|---|---|
| *Patient's Printed Name* | *Responsible Party's Printed Name (must be 18 years or older)* |
| *Patient's Signature* | *Responsible Party's Signature (must be 18 years or older)* |
| *Date* | *Date* |

Who, in addition to yourself, do we have your authorization to contact or speak with regarding your treatment?

*We will only release information to those you have identified here.*

| *Name* | *Phone Number* | *Relationship to you* |
|---|---|---|
| | | |

| *Name* | *Phone Number* | *Relationship to you* |
|---|---|---|
| | | |

*** * FOR OFFICE USE ONLY * ***

We attempted to obtain written Acknowledgement of Receipt of Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barrier prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify): ______________________

Location:

☐ Anthem Periodontics & Dental Implants
851 South Rampart Blvd, Suite 120
Las Vegas, Nevada 89145

☐ Anthem Periodontics & Dental Implants
2610 West Horizon Ridge Pkwy, Suite 202
Henderson, Nevada 89052

| | |
|---|---|
| *Employee's Printed Name* | *Date* |
| *Employee's Signature* | |

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# HEALTH HISTORY

Patient's Name: ______________________ Date of last visit to Physician: __________

Physician's Name: ______________________ Physician's Phone Number: __________

Physician's Cross Streets: ______________________

*Place a mark on "Yes" or "No" to indicate if you have had any of the following:*

| Condition | Yes | No |
|---|---|---|
| AIDS | ____Yes | ____No |
| Anemia | ____Yes | ____No |
| Arthritis, Rheumatism | ____Yes | ____No |
| Artificial Joints | ____Yes | ____No |
| Asthma | ____Yes | ____No |
| Back Problems | ____Yes | ____No |
| Bleeding Abnormally, with extractions or surgery | ____Yes | ____No |
| Blood Disease | ____Yes | ____No |
| Cancer – (Type: ________) | ____Yes | ____No |
| Chemical Dependency | ____Yes | ____No |
| Chemotherapy | ____Yes | ____No |
| Cortisone Treatments | ____Yes | ____No |
| Cough, persistent or bloody | ____Yes | ____No |
| Diabetes | ____Yes | ____No |
| Drug Use (Illegal) | ____Yes | ____No |
| Emphysema | ____Yes | ____No |
| Epilepsy | ____Yes | ____No |
| Fainting or Dizziness | ____Yes | ____No |
| Glaucoma | ____Yes | ____No |
| Headaches | ____Yes | ____No |
| Hepatitis – (Type: ________) | ____Yes | ____No |
| Herpes | ____Yes | ____No |
| HIV Positive | ____Yes | ____No |
| Jaundice | ____Yes | ____No |
| Jaw Pain | ____Yes | ____No |
| Kidney Disease | ____Yes | ____No |
| Liver Disease | ____Yes | ____No |
| Nervous Problems | ____Yes | ____No |
| Prosthetic Replacement | ____Yes | ____No |
| Psychiatric Care | ____Yes | ____No |
| Radiation Treatment | ____Yes | ____No |
| Respiratory Disease | ____Yes | ____No |
| Rheumatic Fever | ____Yes | ____No |
| Scarlet Fever | ____Yes | ____No |
| Shortness of Breath | ____Yes | ____No |
| Sinus Trouble | ____Yes | ____No |
| Skin Rash | ____Yes | ____No |
| Swelling of Feet or Ankles | ____Yes | ____No |
| Swollen Neck Glands | ____Yes | ____No |
| Thyroid Problems | ____Yes | ____No |
| Tuberculosis | ____Yes | ____No |
| Tumor/Growth on Head or Neck | ____Yes | ____No |
| Ulcer | ____Yes | ____No |
| Venereal Disease | ____Yes | ____No |
| Weight Loss, unexplained | ____Yes | ____No |

**Heart Related:**

| Condition | Yes | No |
|---|---|---|
| Artificial Heart Valves | ____Yes | ____No |
| Circulatory Problems | ____Yes | ____No |
| Congenital Heart Lesions | ____Yes | ____No |
| Heart Murmur | ____Yes | ____No |
| High Blood Pressure | ____Yes | ____No |
| Low Blood Pressure | ____Yes | ____No |
| Mitral Valve Prolapse | ____Yes | ____No |
| Pacemaker | ____Yes | ____No |
| Stroke | ____Yes | ____No |
| Other: ________ | ____Yes | ____No |
| Other: ________ | ____Yes | ____No |
| Other: ________ | ____Yes | ____No |
| Other: ________ | ____Yes | ____No |
| Other: ________ | ____Yes | ____No |
| Other: ________ | ____Yes | ____No |
| Other: ________ | ____Yes | ____No |

**Women:**

| Question | Yes | No |
|---|---|---|
| Are you pregnant? | ____Yes | ____No |
| Due Date: ________ | | |
| Are you nursing? | ____Yes | ____No |

## MEDICATIONS

List any and all medications you are currently taking:

______________________

______________________

______________________

______________________

______________________

______________________

Pharmacy Name: ______________________

Pharmacy Phone: ______________________

Pharmacy Cross Streets: ______________________

## ALLERGIES (Check all that apply.)

- ☐ Aspirin
- ☐ Barbiturates (Sleeping Pills)
- ☐ Codeine
- ☐ Iodine
- ☐ Latex
- ☐ Local Anesthetic
- ☐ Penicillin
- ☐ Sulfa
- ☐ No Known Allergies

Other Drugs: ______________________

______________________

______________________

______________________

______________________

I consent to treatment as necessary or desirable to the care of the patient first named above, including but not limited to whatever drugs, medicine, performance of operations, and conduct of laboratory, x-ray, or other studies that may be used by the attending doctor or qualified designate. I also acknowledge full responsibility for the payment of such services and agree to pay them in full at the time of service. I acknowledge that it is my responsibility and not an insurance company to pay for any or all services. Any outstanding balance after 30 days may incur a finance charge of 18% per annum or 1 - 1/2% per month.

______________________
*Responsible Party's Printed Name (must be 18 years or older)*

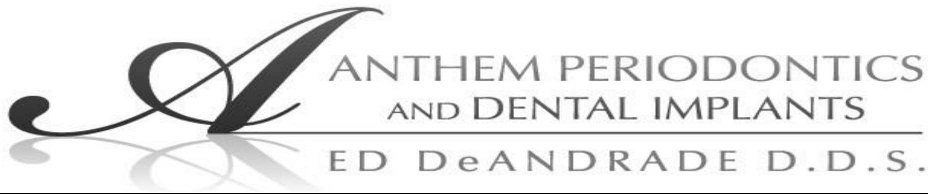
Ed De Andrade, D.D.S.
*Doctor's Printed Name*

______________________
*Responsible Party's Signature (must be 18 years or older)*

______________________
*Doctor's Signature*

______________________
*Date*

______________________
*Date*




DIPLOMATE OF THE AMERICAN BOARD OF PERIODONTOLOGY

# FINANCIAL RESPONSIBILITY ACKNOWLEDGEMENT

Dear Patient:

Thank you for choosing **Anthem Periodontics & Dental Implants** as your health care provider. We appreciate the opportunity to assist you with your dental needs. We believe that having financial matters clear from the onset is preferable to encountering difficulties later.

Our financial policy is as follows:

1. Payments are **due at the time services are rendered**, except for surgical services.

2. Payments for surgical services are **due prior to services rendered**.

3. We accept cash, check, ATM cards, and all major credit cards for your convenience.

4. We will bill your secondary insurance as a courtesy to you, but we will only bill them **once**. We do not bill medical insurance.

5. If your insurance company does not pay your claim within 30 days, we ask that you contact your insurance company. If your insurance company does not pay in full within 60 days, we require you to pay the balance due with cash, check, or credit card.

6. **All charges are your responsibility, whether your insurance company pays or not. You are responsible for knowing what is covered and what is not covered by your insurance. Not all services are covered by insurance; some insurance companies select certain services that they do not cover. Payment for the services that are not covered by your insurance is due when treatment is rendered.** _____ *Please initial.*

7. It is your responsibility to verify that the doctor you are seeing is a provider for your insurance.

8. **A fee of 50% of unpaid balances will be charged to all accounts referred to collections, plus any and all collection fees.**

9. A returned check will be subject to a $25.00 returned check fee.

10. **Twenty four (24) hours notice** is required for cancellations to avoid a broken appointment fee of **$50.00 per hour**. _____ *Please initial.*

I have read and understand the above policies.

| | |
|---|---|
| *Responsible Party's Printed Name (must be 18 years or older)* | *Employee's Printed Name* |
| *Responsible Party's Signature (must be 18 years or older)* | *Employee's Signature* |
| *Date* | *Date* |

DIPLOMATE OF THE AMERICAN BOARD OF PERIODONTOLOGY

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 April 14, 2003, and will remain in effect until we replace it. We reserve the right to change our privacy practices and the terms of this our notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in 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 may 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 or other healthcare provider providing treatment to you. Payments: 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 including quality healthcare professionals evaluating practitioner and provider performance, conducting training programs, accreditation, certification, or credentialing activities.

Your Authorization: in addition to the 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 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 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 or 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 x-rays or other similar forms of health information.

Required by Law: We may use or 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 authorized 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 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. You may also request access by sending us a letter to the address at the end of this Notice. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. 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. Restrictions: You have the right to request that we place additional restrictions on care or disclosure of your health information. We are not required to agree on these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communications: 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 payment will be handled under the alternative means or locations you request. Amendment: You have the right to request that we amend your health information; your request must be written, and it must explain why the information should be amended. We may deny your request under certain circumstances.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us as follows. Anthem Periodontics and Dental Implants, Compliance Officer, 2610 W. Horizon Ridge Pkwy Suite 202, Henderson, NV 89052 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 disclosures of your health information, or to have us communicate with you by alternative means or at alternative location, 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.

## WEBSITE AND SOCIAL MEDIA RELEASE FORM

I hereby grant permission to Anthem Periodontics & Dental Implants, their assigns, licensees, and legal representatives the irrevocable right to use my or my child's story, photographs, radiographs, and other images ("Materials") for publicity, educational, and/or promotional purposes.

I waive any right to inspect or approve any "Materials" to be used. I waive any right to inspect or approve the finished product(s) that may be created and/or posted to Anthem Periodontics & Dental Implants' website, social media outlets, or other mediums in connection therewith.

I hereby release Anthem Periodontics & Dental Implants, their assigns, licensees, and legal representatives from all claims and demands arising out of or in connection with any use of said "Materials", including, without limitation, all claims for invasion of privacy, infringement of my right of publicity, defamation, and any other personal and/or property rights.

I acknowledge and agree that no payment or remuneration or fee of whatsoever nature will be due to me as a result of the use and/or publication or utilization of the "Materials" and waive any rights therein.

☐ Yes, I agree.
☐ No, I decline.

| | |
|---|---|
| Patient's Printed Name | Responsible Party's Printed Name (must be 18 years or older) |
| Patient's Signature | Responsible Party's Signature (must be 18 years or older) |
| Date | Date |