

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:

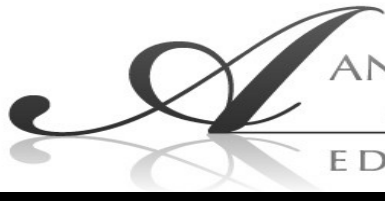
DENTAL HISTORY

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:

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?



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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:

AIDS _____ Yes _____ No	HIV Positive _____ Yes _____ No	Heart Related:
Anemia _____ Yes _____ No	Jaundice _____ Yes _____ No	Artificial Heart Valves _____ Yes _____ No
Arthritis, Rheumatism _____ Yes _____ No	Jaw Pain _____ Yes _____ No	Circulatory Problems _____ Yes _____ No
Artificial Joints _____ Yes _____ No	Kidney Disease _____ Yes _____ No	Congenital Heart Lesions _____ Yes _____ No
Asthma _____ Yes _____ No	Liver Disease _____ Yes _____ No	Heart Murmur _____ Yes _____ No
Back Problems _____ Yes _____ No	Nervous Problems _____ Yes _____ No	High Blood Pressure _____ Yes _____ No
Bleeding Abnormally, with extractions or surgery _____ Yes _____ No	Prosthetic Replacement _____ Yes _____ No	Low Blood Pressure _____ Yes _____ No
Blood Disease _____ Yes _____ No	Psychiatric Care _____ Yes _____ No	Mitral Valve Prolapse _____ Yes _____ No
Cancer - (Type: _____) _____ Yes _____ No	Radiation Treatment _____ Yes _____ No	Pacemaker _____ Yes _____ No
Chemical Dependency _____ Yes _____ No	Respiratory Disease _____ Yes _____ No	Stroke _____ Yes _____ No
Chemotherapy _____ Yes _____ No	Rheumatic Fever _____ Yes _____ No	Are you a smoker? _____ Yes _____ No
Cortisone Treatments _____ Yes _____ No	Scarlet Fever _____ Yes _____ No	Other: _____ Yes _____ No
Cough, persistent or bloody _____ Yes _____ No	Shortness of Breath _____ Yes _____ No	Other: _____ Yes _____ No
Diabetes- (HBA1C Level: _____) _____ Yes _____ No	Sinus Trouble _____ Yes _____ No	Other: _____ Yes _____ No
Drug Use (Illegal) _____ Yes _____ No	Skin Rash _____ Yes _____ No	Other: _____ Yes _____ No
Emphysema _____ Yes _____ No	Swelling of Feet or Ankles _____ Yes _____ No	Other: _____ Yes _____ No
Epilepsy _____ Yes _____ No	Swollen Neck Glands _____ Yes _____ No	Women:
Fainting or Dizziness _____ Yes _____ No	Thyroid Problems _____ Yes _____ No	Are you pregnant? _____ Yes _____ No
Glaucoma _____ Yes _____ No	Tuberculosis _____ Yes _____ No	Due Date: _____
Headaches _____ Yes _____ No	Tumor/Growth on Head or Neck _____ Yes _____ No	Are you nursing? _____ Yes _____ No
Hepatitis - (Type: _____) _____ Yes _____ No	Ulcer _____ Yes _____ No	
Herpes _____ Yes _____ No	Venereal Disease _____ Yes _____ No	
	Weight Loss, unexplained _____ Yes _____ No	

MEDICATIONS

List any and all medications you are currently taking:

ALLERGIES (Check all that apply.)

Aspirin	<input type="checkbox"/>	Local Anesthetic	<input type="checkbox"/>
Barbiturates (Sleeping Pills)	<input type="checkbox"/>	Penicillin	<input type="checkbox"/>
Codeine	<input type="checkbox"/>	Sulfa	<input type="checkbox"/>
Iodine	<input type="checkbox"/>	No Known Allergies	<input type="checkbox"/>
Latex	<input type="checkbox"/>		

Other Drugs: _____

Pharmacy Name: _____

Pharmacy Phone: _____

Pharmacy Cross Streets: _____

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)

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



D I P L O M A T E O F T H E A M E R I C A N B O A R D O F P E R I O D O N T O L O G Y

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 practically 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