HEALTH HISTORY FORM

Patient's Name ______________________________ Date of Birth ____/____/____

Sex (assigned at birth) ________ **Gender Identity** ______________

Preferred pronouns ____________________ **Height** __________ **Weight** ________

Today's Date ____________

DENTAL HISTORY

Please describe your current dental health: Excellent Good Fair Poor

Please describe why you are in the office today______________________________

Have there been any changes in your dental health in the past year? Yes / No

If yes, please describe______________________________

Are you having any dental discomfort at this time? Yes / No

If yes, please describe______________________________

Have you had any adverse effects from dental treatment? Yes / No

If yes, please describe______________________________

Date of last dental visit?______________

DENTAL HISTORY - Do you have or have you ever had any of the following:

Bleeding, sore gums?	Yes / No	Shifting in bite?	Yes / No
Unpleasant taste/bad breath?	Yes / No	Change in bite?	Yes / No
Swelling/lumps in mouth?	Yes / No	Burning tongue/lips?	Yes / No
Orthodontic treatment (braces?)	Yes / No	Frequent blister, lips/mouth?	Yes / No
Clenching/grinding?	Yes / No	Sensitive teeth (hot or cold?)	Yes / No
Sensitive to sweets?	Yes / No	Clicking/popping jaw?	Yes / No
Sensitive to biting?	Yes / No	Difficulty opening or closing jaw?	Yes / No
Food Impaction?	Yes / No	Loose teeth?	Yes / No
Biting cheeks/lips?	Yes / No		

MEDICAL HISTORY

Please describe your current overall health: Excellent Good Fair Poor

Have there been any changes in your general health in the past year? Yes / No

If yes, please describe: ______________________________

Are you now under a doctor's care for a medical condition? Yes / No Date of last physical exam?______________

If yes, please describe______________________________

Name of physician____________________ Physician phone number____________________

Have you ever been hospitalized or had a serious illness? Yes / No

If yes, please describe______________________________

Have you ever had surgery? Yes / No

If yes, please describe______________________________

HEALTH HISTORY FORM

Patient's Name ______________________ Today's Date ________

MEDICAL HISTORY (continued) - Do you have, or have you ever had, any of the following conditions:

Condition	Yes / No	Condition	Yes / No
Congenital heart disease, cardiovascular disease – like heart attack, heart murmur, coronary artery disease, chest pain, high/ low blood pressure, stroke, irregular heartbeat, heart surgery, pacemaker?	Yes / No	Lung disease – like asthma, emphysema, COPD, chronic cough, bronchitis, pneumonia, tuberculosis, shortness of breath, chest pain, severe coughing?	Yes / No
Implants placed anywhere in the body – like heart valve, pacemaker, hip, knee?	Yes / No	Bleeding disorder, anemia, bleeding tendency, blood transfusion, or bruise easily?	Yes / No
Kidney disease or kidney failure, requiring dialysis?	Yes / No	Liver disease – like jaundice, hepatitis A, B, or C?	Yes / No
Thyroid disease?	Yes / No	Arthritis?	Yes / No
Stomach ulcers or colitis?	Yes / No	Significant weight loss or gain?	Yes / No
Diabetes?	Yes / No	Sinus or nasal problems?	Yes / No
Glaucoma?	Yes / No	Sleep apnea?	Yes / No
Cancer?	Yes / No	Osteoporosis or osteopenia?	Yes / No

If yes, type______________________

Diagnosis date______________________

Treatments______________________

Do you have any other medical conditions that are important for your doctor to know about? Yes / No

If yes, please describe____

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FAMILY MEDICAL HISTORY - Do you have a family history of any of the following conditions?

Condition	Yes / No	Relationship	Condition	Yes / No	Relationship
Diabetes?	Yes / No	Relationship__________	Heart disease?	Yes / No	Relationship__________
Lung disease?	Yes / No	Relationship__________	Bleeding problems?	Yes / No	Relationship__________
Cancer?	Yes / No	Relationship__________			

Has an immediate family member had any problems with local anesthesia, general anesthesia, and/or intravenous sedation? Yes / No

If yes, please describe____

MEDICATIONS – Are you currently prescribed or taking any of the following:

Medication	Yes / No	Medication	Yes / No
Antibiotics?	Yes / No	Prescription pain medication?	Yes / No
Anticoagulants or blood thinners?	Yes / No	Aspirin or drugs such as Motrin, Aleve, Ibuprofen?	Yes / No
Heart medications?	Yes / No	Insulin or oral anti-diabetic drugs?	Yes / No
Steroids – like cortisone or prednisone?	Yes / No	Blood pressure medications?	Yes / No
Antianxiety agents, antidepressants, or other psychiatric medications?	Yes / No	Bisphosphonates or other medications to strengthen your bones?	Yes / No
Cancer or chemotherapy drugs?	Yes / No	Any other medications or supplements?	Yes / No

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Patient's Name ______________________________ Today's Date _________

MEDICATIONS (continued): Please list the specific medications indicated above and/or any other medications not listed above that you are currently taking. Please including all prescription medications, diet drugs, over the counter medications, herbal or holistic remedies, vitamins, or minerals:

Medication and dose	Medication and dose

ALLERGIES – Are you allergic to or have you had an adverse reaction to:

Latex?	Yes / No	Codeine or other pain control medications?	Yes / No
Food or food products?	Yes / No	Aspirin, ibuprofen (Motrin), or naproxen (Aleve)?	Yes / No
Sedatives or barbiturates?	Yes / No	Penicillin or other antibiotics?	Yes / No
Any other medications?	Yes / No	Any other allergies?	Yes / No

If yes, please describe______________________________

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ANESTHESIA HISTORY

Have you had any problem associated with local anesthesia, general anesthesia, and/or intravenous sedation? Yes / No

If yes, please describe______________________________

FEMALE PATIENTS Are you pregnant? Yes / No Is there any chance you might be pregnant? Yes / No

SOCIAL HISTORY

Have you ever smoked, vaped or chewed tobacco? Yes / No

If yes, for how long?______________________

Have you ever sought professional care or been hospitalized for:

Substance abuse Yes / No

Emotional disorders Yes / No

Alcoholism Yes / No

Do you use:

Alcohol? Yes / No If yes, how often per week?______

Marijuana? Yes / No If yes, how often per week?______

Recreational drugs? Yes / No If yes, how often per week?______

DO YOU WISH TO TALK TO THE DOCTOR ABOUT ANYTHING IN PRIVATE? Yes / No

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I understand the importance of a truthful and complete health history to assist my doctor in providing coordinated care. To the best of my knowledge, the above information is complete and correct.

______________________________ ______________________________

Signature of patient, parent, guardian Date

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Printed name of patient, parent, guardian/Relationship

HEALTH HISTORY FORM

Patient's Name ______________________________ Today's Date ________

ADDITIONAL MEDICATIONS AND DOSAGES

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ADDITIONAL NOTES

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Patient Number:__________
Procedure(s):

Insurance Verification Form

Please fill out the top half only. Please print.

Did Pt. bring a pano? Yes No

Appointment Date:

Patient's Name:	Address:
Patient's Date of Birth:	Apt# City and Zip:
Patient's Social Security Number:	Phone Number:
E-mail address:	Cell Phone Number:
PRIMARY INSURANCE:	**SECONDARY INSURANCE:**
Employer:	Employer:
Under Whose Name:	Under Whose Name:
Date of Birth:	Date of Birth:
Social Security Number or ID #	Social Security Number or ID #
Group#	Group#
Insurance Phone Number:	Insurance Phone Number:
FOR OFFICE USE ONLY	
Deductible Met: Y / N $	Deductible Met: Y / N $
Oral Surgery %: Prevent %:	Oral Surgery %: Prevent %:
MAX$: USED$: AVAIL$:	MAX$: USED$: AVAIL$:
PPO or HMO Fee Schedule: Spoke to:	PPO or HMO Spoke to: Fee Schedule:
PANO: CONS:	PANO: CONS:
Pre-Authorization Required: Y / N	Pre-Authorization Required: Y / N
Waiting Period: Y / N Tooth Clause: Y / N	Waiting Period: Y / N Tooth Clause: Y / N Start: End: Start: End:
GA: Y / N W/One tooth: Y/N 2 or more teeth in more than 1 quad: Y/N	GA: Y / N W/One tooth: Y/N 2 or more teeth in more than 1 quad: Y/N
Date Verified:	Date Verified:
6010 9612 Effective date:	6010 9612 Effective date:

Privacy Consent

By signing this consent form, you are giving consent to Carlos H Letelier, M.D.,D.M.D.,D.D.S./Center for Oral Surgery and Center for Surgical Arts to use and disclose your protected health information for the purposes of treatment, payment and the health care operations. We have developed a Notice of Privacy Practices that provides more detailed information about how, and under what circumstances, we may use and disclose your protected health information for treatment, payment and health care operations.

Please know that you have the right to review our Notice of Privacy Practices before signing this consent form. In fact, we encourage you to read the entire Notice PRIOR to signing this form. You also have the right to request that we restrict how we may use and disclose your protected health information. We are not required by law, however, to agree to your request. But, if we do decide to grant your request, we are bound by our agreement with you. You also have the right to revoke this consent in writing, unless we have already used or disclosed your protected health information in reliance on this consent.

Dr. Carlos H. Letelier, M.D., D.M.D., D.D.S. may call my home or other designated locations and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out treatment, payment and healthcare operations, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

Dr. Carlos H. Letelier, M.D.,D.M.D.,D.D.S. may mail to my home or other designated locations any items that assist Dr. Carlos H. Letelier, M.D.,D.M.D.,D.D.S. in carrying out treatment, payment, and healthcare operations such as appointment reminder cards and patient statements.

Our Notice of Privacy Practices may be changed from time to time. In the event that we make changes to our Notice, you may obtain a copy of our revised Notice by calling (702)367-6666 or sending a written request to our office.

According to Joint Commission standards, we must inquire if you have a "DO NOT RESUSCITATE" order (DNR) or living will. In the rare event that the need for resuscitation should arise, we resuscitate our patients until paramedics arrive.

In respect of our patients' privacy and healing process, we request no cell phone usage, photos and/or videotaping/recording. This is due to HIPPA confidentiality regulations. Thanks you for your cooperation and respect for our patient's and employee's privacy.

NAME (print): ________________

Signature: ________________________ Date: _______________

OUR FINANCIAL POLICY

Thank you for choosing us as your healthcare provider. We are committed to provide you with a successful treatment and a pleasant experience. Our Insurance Department and Patient Finance Counselors will work very hard to make sure that you get the maximum reimbursement possible.

INSURANCE AND INSURANCE COLLECTION

Insurance reimbursement can be a long and difficult process for our office. In fact, insurers will routinely stall, deny and reduce payments. It is much easier to maximize your reimbursement if we work together to get your claim processed so you may be asked to call and check claim status if the claim has not been paid past thirty (30) days. After your surgery, insurance companies occasionally reimburse you, the patient, even though an assignment of benefits has been properly executed. Should this occur and your balance has not been satisfied, you are obligated to endorse and forward all payments to this office within 24 hours.

FORMS OF PAYMENT

We accept Cash, Checks, all major credit cards, debit cards and check cards. We offer *CareCredit and Lending Club* as our extended payment options. Our Patient Finance Counselors can give you details on how to apply.

INSURANCE CO-PAYMENTS

We verbally obtain your benefits from your insurance and determine your estimated co-payment, however, this is an estimate only and this does not alleviate you of your financial obligations. After your claim is submitted and paid, you may still have a remaining balance and will receive a statement due upon receipt.

TYPES OF INSURANCE

Non-Contracted or Indemnity Insurance Plan:

We will bill your insurance as a courtesy, a convenience, and a service to you; however, we may require 100% of the bill to be paid at the time of service.

PPO Dental Plans:

We are providers with several dental insurance carriers. Please verify with our office staff if your insurance is one we are contracted with. If we are a contracted provider, your percentage co-pay plus any deductible is collected on the date of service. We obtain verbal estimates from your insurance company regarding your benefits for your treatment on the date of service. This amount may not reflect pending claims or non covered procedures. Additional monies may be due after insurance receives claim and processed according to your plan.

Medical Insurance:

This office is NOT all Provider with most medical insurance carriers. For most medical treatments provided, you may be asked for payment in full at the time of service. Please note that your insurance may deny the claim if you have not pre-authorized your surgical procedure or elected to go out of network. We will be happy to bill them as a courtesy to you. Because we are accredited with the Joint Commission, a claim may be submitted to your medical insurance for a facility fee (The Center for Surgical Arts) and supplies. The patient will not be responsible for the amount the insurance does not pay on this claim. However, if payment is sent to you, we ask that you forward it to our office.

Medicaid:
You must have a valid, full benefit Medicaid card for the current month along with a picture ID. You are responsible for payment of procedures not covered by Medicaid. This office does not accept pending Medicaid status or the HMO plan with Anthem BCBS, Silver Summit Healthplan, Liberty Dental & HPN.
Secondary Insurers:
Having more than one insurances DOES NOT necessarily mean that your services are covered 100%. Insurances do a coordination of benefits, and secondary insurers will pay as a supplement of what your primary carrier pays. We may bill your secondary carrier as a courtesy. You are responsible for any balance after your insurance(s) has paid.
Dental Implants/Cosmetic Procedures:
Extended appointments are provided and components must be ordered for these types of procedures. Only rarely is insurance coverage available to cover these fees. In order to secure your surgery date/time, all fees are due and payable one week prior to your scheduled procedure(s).
Bone Grafting, Biopsies and Removal of lesions
Frequently, these procedures are not covered by insurance plans. For this reason, we require payment for these procedures at the time of service. As a courtesy, we will bill your insurance company and attempt to obtain coverage. If any payment is made by your insurance company for these procedures, we will reimburse you the corresponding amount.
CT Scans:
CT scans may not be a covered benefit with your insurance, so we do ask for the fee at the time of service. We will bill your insurance as a courtesy to you. If your insurance pays, it will then be reimbursed to you. If we are a provider with your insurance and your insurance allows CT scans, you will get the provider fee.
Usual and Customary Rates:
Our practice is committed to providing the best treatment for our patients. You are responsible for payment regardless of the insurance company's arbitrary determination of usual and customary rates.
Divorce Decrees:
This office is NOT a party to any divorce decrees. Adult patients are responsible for their bill at the time of service. The responsibility for minors rests with the accompanying adult.
Unplanned Procedures:
Surgery is not an exact science. As such, procedures not initially contemplated may be necessary during your surgery or at a later date. This may include a post-operative x-ray which may be necessary following your procedure. Further charges may apply.
Minor Patients:
The adult accompanying a minor and the parents (or guardians) of the minor are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan.
Refunds:
In the event that your account is overpaid after we receive payment from your insurance, refunds will be made at the beginning and in the middle of the month and mailed in the name of the patient.
Collections:
Please be advised that this office cooperates with the Clark County District Attorney's Office to prevent bad check losses. Unless satisfactory arrangements are made with our Financial Department, delinquent accounts are sent to a collection agency. Please be aware that being referred to this type of agency may adversely affect your credit rating.
I have read and understand each section in this financial policy. By signing this form, I agree to all the procedures and policies described.

______________________________ ____________
Signature of Responsible Party Date

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