PATIENT INFORMATION

Welcome to our office. We appreciate the confidence you place with us to provide dental services. To assist us in serving you, please complete the following form. The information provided on this form is important to your dental health. If there have been any changes in your health, please tell us. If you have any questions, don't hesitate to ask.

Patient Name: _____ Date of Birth: _____ Sex: _____ Age: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Billing Address *(If different)*: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____ Email: _____

Driver's License Number: _____ State: _____ SS#: _____

Employer/Occupation: _____ Business Phone: _____

Spouse's name & phone #: _____ Emergency Phone # *(other than spouse*): _____

Primary dental insurance: _____ Group #: _____

Secondary dental insurance: _____ Group #: _____

Subscriber's name: _____ Date of birth: _____ SS #: _____

Name of your medical doctor: _____ Date of last visit to medical doctor: _____

Name of previous dentist: _____ Date of last visit to dentist: _____

Reffered to us by: _____ _____

Consent for Treatment

I. l hereby authorize the doctor or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of (name of patient) _____ 's dental needs.

2. Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

3. I agree to the use of anesthetics, sedatives and other medication necessary. l fully understand that using anesthetic agents-embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

4. Lastly, I agree to be responsible for payment of all services rendered (including insurance estimated portion) on my behalf or my dependents. I understand that payment is due at the time of the service unless other arrangements have been made. As a comtesy, your insurance will be billed. However, patient's out-of- pocket expenses and deductibles are due at the time services are rendered. Account balances that exceed 90 days are subject to collection actions as well as additional collection expenses and finance charges (2% monthly or 24% annually).

X_____ Date: _____ Print Name: _____

Patient/Legal Representative Signature

Time 10:00 AM

Incline Dental Care LLC
Medical History

Patient Name: _____ Birth Date: _____ Date Created: _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important Interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Do you see a Primary Care Physician? Name?	☐ Yes	☐ No	If yes
Have you ever been hospitalized or had a major operation?	☐ Yes	☐ No	If yes
Have you ever had a serious head or neck injury?	☐ Yes	☐ No	If yes
Are you taking any medications, pills, or drugs?	☐ Yes	☐ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	☐ Yes	☐ No	If yes
Are you on a special diet?	☐ Yes	☐ No	If yes
Are you on anti-coagulant (blood thinner) therapy?	☐ Yes	☐ No	If yes
Do you use controlled substances?	☐ Yes	☐ No	If yes
Do you use tobacco?	☐ Yes	☐ No	If yes
Has a physician ever recommended that you take antibiotics prior to dental treatment?	☐ Yes	☐ No	If yes

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic
☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Other allergies? ☐ Yes ☐ No If yes

Women: Are you...
☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Do you have, or have you had, any of the following?

AIDS/HIV Positive	☐ Yes ☐ No	Cortisone Medicine	☐ Yes ☐ No	Hemophilia	☐ Yes ☐ No	Radiation Treatments	☐ Yes ☐ No
Alzheimer's Disease	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	Swelling of Limbs	☐ Yes ☐ No	Anaphylaxis	☐ Yes ☐ No
Drug Addiction	☐ Yes ☐ No	Hepatitis A, B or c	☐ Yes ☐ No	Renal Dialysis	☐ Yes ☐ No	Anemia	☐ Yes ☐ No
Herpes	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No	Angina	☐ Yes ☐ No	Emphysea	☐ Yes ☐ No
High Blood Pressure	☐ Yes ☐ No	Rheumatism	☐ Yes ☐ No	Arthritis/Gout	☐ Yes ☐ No	Epilepsy or Seizures	☐ Yes ☐ No
High Cholesterol	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No	Artificial Heart Valve	☐ Yes ☐ No	Excessive Bleeding	☐ Yes ☐ No
Hives or Rash	☐ Yes ☐ No	Shingles	☐ Yes ☐ No	Joint Replacement	☐ Yes ☐ No	Hypoglycemia	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Fainting Spells/Dizziness	☐ Yes ☐ No	Irregular Heartbeat	☐ Yes ☐ No	Sinus Trouble	☐ Yes ☐ No
Blood Disease	☐ Yes ☐ No	Frequent cough	☐ Yes ☐ No	Kidney Problems	☐ Yes ☐ No	Spine Bifida	☐ Yes ☐ No
Blood Transfusion	☐ Yes ☐ No	Leukemia	☐ Yes ☐ No	Stomach/Intestinal Disease	☐ Yes ☐ No	Breathing Problems	☐ Yes ☐ No
Frequent Headaches	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Stroke	☐ Yes ☐ No	Bruise Easily	☐ Yes ☐ No
Low Blood Pressure	☐ Yes ☐ No	Cancer	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Lung Disease	☐ Yes ☐ No
Thyroid Disease	☐ Yes ☐ No	Chemotherapy	☐ Yes ☐ No	Mitral Valve Prolapse	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Chest Pains	☐ Yes ☐ No	Heart Attack/Failure	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Cold Sores/Fever Blisters	☐ Yes ☐ No	Heart Murmur	☐ Yes ☐ No	Pain in law Joints	☐ Yes ☐ No	Tumors or Growths	☐ Yes ☐ No
Congenital Heart Disorder	☐ Yes ☐ No	Heart Pacemaker	☐ Yes ☐ No	Parathyroid Disease	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No
Heart Trouble/Disease	☐ Yes ☐ No	Mental illness	☐ Yes ☐ No				

Have you ever had any serious Illness not listed: ☐ Yes ☐ No If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing Incorrect Information can be dangerous to my (or patient's) hearth. It is my responsibility to inform the dental office of any changes in medical status.

X_____ Date: _____
Signature of Patient, Parent or Guardian

PATIENT DENTAL HISTORY

PATIENT'S NAME: _____ BIRTH DATE: _____

REASON FOR THIS VISIT: _____

WHEN WAS YOUR LAST DENTAL VISIT: _____ WHAT WAS DONE THEN: _____

HOW OFTEN DID YOU VISIT THE DENTIST BEFORE THEN: _____

PREVIOUS DENTIST (NAME AND LOCATION): _____

HAVE YOU HAD A COMPLETE SERIES OF DENTAL FILMS (X-RAYS) TAKEN-WHEN & WHERE: _____

HOW OFTEN DO YOU BRUSH YOUR TEETH: _____ HOW OFTEN DO YOU FLOSS YOUR TEETH: _____

IS YOUR DRINKING WATER FLUORIDATED ☐ YES ☐ NO

	Yes	No
Do your gums bleed white brushing or flossing.....	☐	☐
Are your teeth sensitive to hot or cold liquids/foods.....	☐	☐
Are your teeth sensitive to sweet or sour liquids/foods.....	☐	☐
Do any of your teeth feel painful.....	☐	☐
Do you have any sores or lumps in or near your mouth.....	☐	☐
Have you had any head, neck, or jaw injuries.....	☐	☐
Have you experienced any of the following problems:		
Clicking in your jaw.....	☐	☐
Pain(joint, ear, side of face).....	☐	☐
Difficulty in opening and closing your jaw.....	☐	☐
Difficulty in chewing.....	☐	☐
Do you have frequent headaches.....	☐	☐
Do you clench or grind your teeth.....	☐	☐

	Yes	No
Do you bite your lips or cheeks frequently.....	☐	☐
Have you noticed any loosening of your teeth.....	☐	☐
Does food lend to become caught between your teeth.....	☐	☐
Have you ever had periodontal treatment (gums).....	☐	☐
Have you ever worn a bite plate or other appliance.....	☐	☐
Have you had any difficult extractions in the past	☐	☐
Have you ever had any prolonged bleeding following:		
Extractions.....	☐	☐
Do you wear dentures or Partials.....	☐	☐
If yes, give the date they were placed:		
_____		
Have you ever received oral hygiene instructions regarding the care of your teeth and gums.....	☐	☐

IF YOU COULD CHANGE ANYTHING ABOUT YOUR SMILE, WHAT WOULD YOU CHANGE?

AUTHORIZATION AND RELEASE:

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION TO THE OEST OF MY KNOWLEDGE. THE ABOVE QUESTIONS HAVE BEEN ACCURATELY ANSWERED. INFORMATION I UNINCLUDING OERST AND THE THAT DIAGNOSIS PROVIDING AND THINCORRECT INFORMATION CAN BE DANGEROUS TO MY HEAL TH. I AUTHORIZE THE DENTIST TO RELEASE ANY INFORMATION INCLUDING THE DIAGNOSIS AND THE RECORDS OF ANY TREATMENT AND EXAMINATION RENDERED TO ME OR MY CHILD DURING THE PERIOD OF SUCH DENTAL CARE TO THIRD PARTY PAYORS 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.

_____ _____

SIGNATURE OF PATIENT OR PARENT/GUARDIAN IF MINOR: *DATE*

_____ _____

DOCTOR'S SIGNATURE: *DATE*

DOCTOR'S COMMENTS: _____

X-Ray Policy

X-rays provide one of the best diagnostic tools in dentistry enabling dentists to see the tissues of the teeth and jaw bones. We assure you that we are conservative in our use of x-rays, but without them, decay and other diseases of the mouth and facial bones cannot be diagnosed until serious damage has been done. We will never take unnecessary x-rays.

We utilize the latest in digital x-ray technology which means you're getting a very low radiation dose at our office. Our x-ray machines are licensed and routinely inspected by the State of Nevada.

New Patients

It is our policy that we have current dental x-rays for all new patients. This includes a full mouth series and a panorex when indicated by Dr. Milligan. If you have current x-rays from a previous dental office we will be happy to use them. If your requested x-rays from your previous office have not arrived by the time of your first visit, or they are not of diagnostic quality, new x-rays will be needed. This full mouth series will be needed every three to five years.

Check-up X-rays

Depending your risk of dental disease, check-up x-rays will most likely be required once per year and will be completed at your hygiene visit.

I have read and agree to the x-ray policy of Incline Dental Care

_____	_____	_____
Patient Signature	*Print Name*	*Date*

INCLINE DENTAL CARE

ACKNOWLEDGEMENT of RECEIPT of "NOTICE of PRIVACY PRACTICES"

I _____ have received a copy of the "Notice of Privacy Practices" of Incline Dental Care.

_____
Name (Please Print)

_____ _____
Sign Date

Please Note: It is your right to refuse to sign this acknowledgement.

If signing on behalf of the above individual:

Personal representatives name: _____

Relationship to above individual: _____

Office Use Only

We tried to obtain written acknowledgement by the individual noted above of recepit of our Notice ot Privacy Practices but it could not be obtained because:

- ☐ An emergency prevented us from obtaining acknowledgement
- ☐ A communication barrier prevented us from obtaining acknowledgement.
- ☐ The individual was unwilling to sign.
- ☐ Other: _____

Staff or Privacy director's name: _____

Staff Signature: _____ Date: _____