Brian G. Sanford D.D.S
2551 N. Green Valley Pkwy Suite C-301
Henderson, NV 89014
702-451-8181

Welcome! We are pleased to have you at our office. So that we may properly handle your account and the billing of your insurance claims, **please fill this form out completely.**

Patient Information:

Name: _____ Date: _____
Date of Birth: _____ Social Security Number: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone/Cell: _____ Email: _____
Person Responsible for Account: _____
Address: _____ Relationship to patient: _____ DOB: _____ Ph#: _____
Primary Insurance: _____ ID/SS# _____
Subscriber Name: _____ DOB of Subscriber: _____
Group Name: _____ Group # _____
Dental Insurance Ph# _____ Claim Address: _____
Secondary Insurance: _____ ID/SS# _____
Subscriber Name: _____ DOB of Subscriber: _____
Group Name: _____ Group # _____
Dental Insurance Ph# _____ Claim Address: _____
Who can we thank for referring you to our office: _____

Please understand that your payment of your bill is part of your treatment and the following is a statement of our financial policy, which you are required to read and sign. Your insurance is a contract between you and/or your employer and the insurance company. All benefits given are an **ESTIMATE.** _____ **Initials**

- We know life can be busy, we respect your time and ask you do with us as well. On a case-by-case situation, Appointments that are NOT confirmed by End of business day, 2 days prior to appointment, your appointment will be removed from the schedule. _____ **Initials**
- All Patient is responsible to provide updated dental insurance/Patient information.
- Full payment is due at the time of service, unless prior arrangements have been made.
- co-pays, co-insurance, deductible payments are due at the time of check out.
- Any balance due from prior visits must be paid prior to any subsequent visits.
- Any patient who fails to show up to their appointment or late cancel or reschedule will be charged $50.00/hr. We ask at least 48 business hour notice. _____ **Initials**
- Please know that waiving deductibles and copays charges is illegal and breach of contract with your insurance company.
- A pre-authorization is not mandatory with your insurance, should you request for one please let our office staff aware. Keep in mind that pre-authorization may take up to 8 weeks from your insurance and still **not** a guarantee of payment.

I have read the financial policy described above and understand and agree to all provisions.

Print Name: _____ Signature: _____ Date: _____

Dental-Medical History

Name of Physician: _____ Phone: _____

☐ Yes ☐ No Are you in good physical health? Date of last physical: _____
☐ Yes ☐ No Are you under a physician's care? Why? _____
☐ Yes ☐ No Are you taking any medications? List: _____

☐ Yes ☐ No Do you have heart problems?
☐ Yes ☐ No Have you had heart valve replacement surgery?
☐ Yes ☐ No Do you have a heart murmur?
☐ Yes ☐ No Have you had joint replacement surgery?
☐ Yes ☐ No Have you ever used Phen-Fen for weight loss?
☐ Yes ☐ No Have you ever had an echocardiogram?
☐ Yes ☐ No Do you bleed or bruise easily?
☐ Yes ☐ No Are you subject to fainting?
☐ Yes ☐ No Women Patients: Are you pregnant? Due Date: _____
☐ Yes ☐ No Do you have any allergies to any medications including penicillin? List: _____

☐ Yes ☐ No Are you allergic to any metals? What? _____
☐ Yes ☐ No Have you ever tested positive for HIV/AIDS?

Do you now have or have you ever had...

☐ Yes ☐ No Rheumatic Fever
☐ Yes ☐ No Blood Disorder
☐ Yes ☐ No Lupus
☐ Yes ☐ No Epilepsy
☐ Yes ☐ No Asthma
☐ Yes ☐ No Diabetes
☐ Yes ☐ No Tuberculosis
☐ Yes ☐ No Hepatitis Type: _____
☐ Yes ☐ No High Blood Pressure

☐ Yes ☐ No Any other condition we should be aware of? _____

Dental History

☐ Yes ☐ No Do you have sensitivity or allergy to Latex?
☐ Yes ☐ No Have you ever had an adverse or severe reaction to dental treatment?
☐ Yes ☐ No Have you had any problems with oral anesthetics, epinephrine?
☐ Yes ☐ No Do you have any problems that could be aggravated by reclining in a dental chair?
☐ Yes ☐ No Are you pleased with your smile? Concerns? _____
☐ Yes ☐ No Are you interested in whitening your teeth?
☐ Yes ☐ No Do you use tobacco products? What kind? _____ How Often? _____
☐ Yes ☐ No Do you have any muscle soreness when chewing food or gum?
☐ Yes ☐ No Do your gums bleed?

Date of your last: Dental visit? _____ Cleaning? _____ X-rays? _____
Is there anything you would like us to be aware of? _____

Authorization

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist. I understand that I am financially responsible for all charges whether or not paid by the insurance company.

Signature: _____ Date: _____

Brian G. Sanford D.D.S.
2551 N. Green Valley Pkwy Bldg. C., Suite 301
Henderson, NV 89014
702-451-8181

Patient Consent Form

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of, and given the right to review and secure a copy of you *Notice of Privacy Practices,* which contains a more complete description of the uses and disclosures of my protected information, and my right s under HIPAA. I understand that you reserve the right to change the terms of the notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and healthcare operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date that I revoke this consent is not affected.

_____ _____
Signature of Patient or Guardian Date

_____ _____
Print Name Relationship to patient

Brian G. Sanford D.D.S
2551 N. Green Valley Pkwy., Bldg. C Ste. 301
Henderson, Nevada 89014
702.451.8181

Consent for Treatment & Financial Policy

1. I hereby authorize Dr. Sanford or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by Dr. Sanford to make a thorough diagnosis of (patient's name) _____'s dental needs.
2. Upon such diagnosis, I authorize Dr. Sanford 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 as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.
4. **I agree to financial responsibility for all charges incurred for services rendered on my behalf or my dependants regardless of insurance coverage. I understand that payment is due at the time of service.**
5. In the event that payment in full for charges incurred is not made, I agree to pay all costs of collection including a 35% collection fee, attorney fees, court costs and interest at the rate of 1.5% per month (18 % annum). I also agree to submit myself to the jurisdiction of the courts of Clark County, Nevada. _____ Date
6. To all patients with dental insurance: Your dental insurance is a contract between you and/or your employer and the insurance company. All benefits given are an estimate. Your insurance company may have arbitrarily set maximum allowable amounts for certain procedures. Any amount over that maximum is considered patient responsibility.

_____ _____
Signature of Patient or Guardian Date

_____ _____
Print name Relationship to patient

_____
Witness Signature

Name:________________________________

Exam Date:__________

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BWX: Yes No		
Perio:		
Med Hx Update:		

Notes:__________________

Exam Date:__________

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Perio:		
Med Hx Update:		

Notes:__________________

Exam Date:__________

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BWX: Yes No		
Perio:		
Med Hx Update:		

Notes:__________________

Exam Date:__________

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BWX: Yes No		
Perio:		
Med Hx Update:		

Notes:__________________