Vegas Dental Experts

6870 S. Rainbow Blvd. Suite #119
Las Vegas, NV 89118
(702)876-6067

560 Marks Street
Suite B
Henderson, NV 89014
(702)204-8303

Please check the box for the office your appointment is scheduled

Patient Information

Date: _____

Patient Name: _____ DOB: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Cell Phone: _____ Email: _____

☐ Female ☐ Male Age: _____ SS#: _____ ☐ Married ☐ Single ☐ Widowed

Employer: _____ Occupation: _____

How did you hear about our office? _____

Person to contact in case of an emergency: _____ Phone: _____

Person responsible for Account: _____ Relationship: _____

Address: _____

Phone: _____ Cell: _____ Email: _____

Insurance: Primary

Name of Insured: _____ DOB: _____

SS# | Subscriber ID#: _____ Relationship: _____

Employer Providing Insurance: _____

Insurance carrier: _____ Ins Phone: _____

Address: _____

Group #: _____ Employer | Group Plan: _____

Secondary

Name of Insured: _____ DOB: _____

SS# | Subscriber ID#: _____ Relationship: _____

Employer Providing Insurance: _____

Insurance carrier: _____ Ins Phone: _____

Address: _____

Group #: _____ Employer | Group Plan: _____

General Health Information: Patient: _____ Date: _____

Dental History:

Reason for today's visit: _____

Are there any dental conditions we should be aware of: _____

When was your last dental visit: _____ What treatment was done: _____

When were your last dental x-rays? _____

Have you had a Cleaning ◯ Yes ◯ No | Have you ever had deep cleanings ◯ Yes ◯ No | Do you grind your teeth ◯ Yes ◯ No

Prolonged bleeding with extractions ◯ Yes ◯ No | Do you have bad breath ◯ Yes ◯ No | Do you floss daily ◯ Yes ◯ No

Do your gums bleed easy ◯ Yes ◯ No | Have you been diagnosed with TMJ issues ◯ Yes ◯ No

Do you have sensitive teeth ◯ Yes ◯ No | Would you like to whiten your teeth Yes ◯ No | Do you like your smile ◯ Yes ◯ No

Have you had any issues with Dental treatment in the past ◯ Yes ◯ No

Medical History:

Are you under the care of a Physician at this time ◯ Yes ◯ No If so, why: _____

Physician's Name: _____ Phone: _____

Are you allergic to: (please circle all that apply)

Penicillin Codeine Local Anesthetics Sulfa Aspirin Tranquilizers Latex other: _____

Are you taking ANY medications at this time: (including over the counter | birth control | diet aids)

_____

_____

Women: are you pregnant? ◯ Yes ◯ No If so, due date: _____ Are you Nursing? ◯ Yes ◯ No

Have you ever taken antibiotics before dental treatment ◯ Yes ◯ No if so, why? _____

Do you have any of the following: (please check yes or no to all that apply)

◯ Yes ◯ No	Artificial Valve	◯ Yes ◯ No	Aids/HIV	◯ Yes ◯ No	Anemia	◯ Yes ◯ No	Angina
◯ Yes ◯ No	Arthritis	◯ Yes ◯ No	Asthma	◯ Yes ◯ No	Bisphosphonate Therapy	◯ Yes ◯ No	Cancer
◯ Yes ◯ No	Chemo	◯ Yes ◯ No	Bleeding Problems	◯ Yes ◯ No	Diabetes	◯ Yes ◯ No	Dizzy Spells
◯ Yes ◯ No	Drug Addiction	◯ Yes ◯ No	Emphysema	◯ Yes ◯ No	Epilepsy	◯ Yes ◯ No	Fainting
◯ Yes ◯ No	Glaucoma	◯ Yes ◯ No	Hepatitis	◯ Yes ◯ No	Heart Attack/surgery	◯ Yes ◯ No	Jaundice
◯ Yes ◯ No	Pacemaker	◯ Yes ◯ No	Heart murmur	◯ Yes ◯ No	Joint replacement	◯ Yes ◯ No	Lung Disease
◯ Yes ◯ No	Kidney Disease	◯ Yes ◯ No	Latex Allergy	◯ Yes ◯ No	Liver problems	◯ Yes ◯ No	Sinus issues
◯ Yes ◯ No	Low Blood Pressure	◯ Yes ◯ No	High Blood pressure	◯ Yes ◯ No	Psychiatric care	◯ Yes ◯ No	Rheumatic fever
◯ Yes ◯ No	Sleep Apnea	◯ Yes ◯ No	Thyroid issues	◯ Yes ◯ No	Tobacco use	◯ Yes ◯ No	Stroke
◯ Yes ◯ No	TMD/TMJ	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No	Venereal disease	◯ Yes ◯ No	Cold Sores

Any issues we should be aware of: _____

To the best of my knowledge, I have answered every question completely and accurately. I will inform the office of any changes in my health and/or medications. I further certify that I consent to taking x-rays and an oral examination.

Patient/Parent/Guardian's Signature: _____ **Date:** _____

Doctor's Signature: _____ Date: _____

Vegas Dental Experts

Please be advised that during the course of your treatment our office may need to coordinate/collaborate with additional providers such as but not limited to:

Dental Professionals
Oral Surgeons
Endodontists
Periodontists
Orthodontists
Dental Labs
Case Planning Specialists
Insurance Companies and/or their consultants

I, _____, give my permission for Vegas Dental Experts to share my patient demographics, x-rays, treatment plan, and treatment ledger as it relates to insurance billing, with the appropriate dental professionals as needed to coordinate/collaborate in the best interest of my dental care.

Also, I would like to give my dental office permission to disclose my complete dental health record including, but not limited to, appointments, diagnoses, labs, treatment plans, and billing records for all conditions with the following individual:

Name: _____ Relationship: _____

Phone: _____

I understand that I am permitted to revoke this authorization to share my health data at any time and can do so by submitting a request in writing to:

Vegas Dental Experts
6870 S. Rainbow Blvd. Suite #119
Las Vegas, NV. 89118

Signature: _____ Date: _____

Print your name: _____ DOB: _____

If this form is being completed by a person with legal authority to act an individual's behalf, such as a parent or legal guardian of a minor or health care agent, please complete the following information:

Name of person completing this form: _____

Signature of person completing this form: _____

OFFICE FINANCIAL GUIDELINES

In our continued commitment to provide the highest quality dental are available to all of our patients and to have those services comfortably affordable, we are pleased to offer you these options for payment:

Personal payments: Cash Personal Checks (for established patients only) Credit Cards Cashier's Check **Finance Companies *OAC:** CareCredit Alpheon Credit	**Pre-Payment:** **We are happy to offer a 5% discount for services over $300.00 when prepaid in full with cash upon scheduling the appointment**

Dental Insurance Guidelines

We are committed to support you in understanding your dental health, so that you will always be able to make the best choices regardless of insurance coverage, downgrades, and exemptions. As a courtesy, we will process your insurance benefits in our office however, you are fully aware that **all fees are your responsibility regardless of insurance coverage.** If your insurance fails to pay, the balance due is completely the patient's responsibility. If, in the event this balance goes unpaid, 3 statements will be sent along with letters requesting said balance. I**f after 90 days the balance still remains unpaid, the undersigned/patient agrees to pay the processing fee of up to 40%. In the event of legal recovery of unpaid balance, the undersigned/patient further agrees to pay court costs and attorney fees.**

Missed Appointments

We go to great lengths in this office to see that you receive quality personal dental care. Our ability to offer service to you in this personal manner is directly dependent upon your cooperation. When making appointments, we reserve time specifically for you with our staff. Cancellations, no shows, and missed appointments cost the staff, Doctor, Office, and the patients. If you must make a change to your reserved time, we ask that you please do so at least **48 hours prior to your scheduled visit. Our guideline is to charge $50.00 per half-hour for missed appointments.** Please help us serve you better by keeping your scheduled appointments. You will get a reminder call, email, and/or text prior to your appointment. Please be responsible and make a note of your appointment to avoid this No-show fee.

We are here to assist you in any way possible. Please make sure your questions and concerns are known by the team…our goal is to ensure you have an outstanding experience.

* The Financial policies of the practice have been fully explained to me and I acknowledge full responsibility for all charges incurred, regardless of possible dental Insurance coverage or denial. I hereby authorize the practice to obtain, in my behalf, any insurance information covered by "The Privacy Act" for my insurance company(s) file. I authorize payment directly to the provider's office for dental benefits.

Patient: _____ Date: _____

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Patient Photo Release Form

I, _____, hereby authorize Dr. Harvey Chin and his team at Vegas Dental Experts or any of his assignees to take photographs, slides, videos of my teeth, jaws and face. I understand that the photographs, slides, and videos will be used as a record of my care, and may be used for communication with other health care professionals, educational publications (dental journals), and educational lectures. The content may also be used for advertising purposes (including website publication, Facebook posts, etc).

I further understand that if the photographs, slides and videos are used in any publication or as a part of a demonstration, my identifying information (first name only) could be used unless stated differently below. I do not expect compensation, financial or otherwise, for the use of these photographs. If I wish to evoke this consent, I may do so in writing by registered mail.

If declining this consent, leave blank.

Please initial one option:

_____ I do not mind if my photographs are used in any of the above stated situations.

_____ I only agree to have my teeth shown without any identifying features.

Signature _____ Date_____

Printed Name _____