Apex Endodontics

Name _____ DOB _____ Soc. Sec. # _____-_____-_____
Last Name First Name MI

Address _____ City _____ State _____ Zip _____

How did you hear about us? _____

Sex: F M Marital Status _____ Drivers License # _____

Home Phone _____ Cell Phone _____ Work Phone _____

Patient is a student ☐Yes ☐No If yes, school _____ ☐Full time ☐Part time

Employer _____ Email Address _____

Emergency Contact Name _____ Home/Cell Phone _____ Work Phone _____

Responsible Party Information (if other than patient above)

Person responsible for paying fees _____
Last Name First Name Middle Ini

Social Security #_____ DOB _____ Relationship to pt _____ Resp. Party Drivers License #_____

Address _____ City_____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone_____

Dental Insurance boxes MUST be filled out COMPLETELY.

Dental Insurance

Subscriber Name _____

Relation to patient _____DOB _____

Subscriber Soc. Sec.# _____-_____-_____

Subscriber Address _____

City _____State _____Zip_____

Subscriber Employer _____

Work Phone _____

Insurance Company _____

Ins. Company Phone Number _____

Insurance Company Address _____

Subscriber # _____ Group # _____

Secondary Dental Insurance (If apply.)

Subscriber Name _____

Relation to patient _____DOB _____

Subscriber Soc. Sec.# _____-_____-_____

Subscriber Address _____

City _____State _____Zip_____

Subscriber Employer _____

Work Phone _____

Insurance Company _____

Ins. Company Phone Number _____

Insurance Company Address _____

Subscriber # _____ Group # _____

Name _____ **DOB** _____
Last Name **First Name**

All information given is strictly confidential and will not be released to anyone without approval. It is for your safety that our doctors know your entire medical/dental history to provide safe and complete treatment. Thank you for completing the following questionnaire.

Main reason for this visit: _____

If time permits, I would also like to discuss: _____

General Dentist Name _____ Phone # _____

Family Physician Name _____ Phone # _____

__No __Yes Are you allergic to any medications, foods or products such as latex? If yes, Please list:

_____

__No __Yes Have you ever taken any Bis-phosphonate medications (ie: Zometa, Aredia, Boniva, Actonel, Fosamax, Skelid, Didronel?) If yes, please specify dates and reason for taking. from_____ to_____ for _____

Are you pregnant? __No __Yes Are you breastfeeding? __No __Yes Are you taking birth control medications? __No __Yes

What is/was your occupation(s) _____ Are you married? __No __Yes

List all medications you are currently taking. Please include all prescription, inhaler, homeopathic, and herbal medications:

_____

_____

Check any of the following that you have had or presently have:

Bone, joint, & muscle
__Artificial joint
__Metal plates and screws
__Prior bone/joint infection
__Osteoporosis
__Back problems
__Arthritis
__Jaw joint problems/TMJ

Cancers
__Where_____
__When _____
__Chemotherapy
__Radiation therapy

Chemical dependency
__Drug
__Alcohol

Tobacco use
__Smoke ____pk/day for ___yrs
__Dip ____cans/day for ___yrs

Circulatory conditions
__High blood pressure
__Clotting problems
__Anemia
__Hemophilia/easy bruising
__Feet/ankle swelling

Glandular conditions
__Diabetes, type _____
__Thyroid problems

Brain and nervous system
__Stroke
__Seizure/Epilepsy
__Dementia

Heart conditions
__Heart attack (MI)
__Heart murmur
__Heart failure
__Heart surgery/bypass
__Pacemaker
__Angina (chest pain)
__Rheumatic fever
__Artificial heart valve/stents

Lung conditions
__Asthma
__Pneumonia/Bronchitis
__Emphysema
__Shortness of breath
__Tuberculosis

Psychiatric conditions
__Anxiety
__Depression/bipolar
__Schizophrenia

__Hepatitis A/B
__HIV/AIDS
__Kidney disease/transplant
__Liver disease/transplant
__Skin disease/cancer
__Sleep apnea/snoring
__Sinus problems
__Hay fever/allergies
__Glaucoma
Other _____

List all serious illnesses, hospitalizations, and surgeries in the last 5 yrs_____

Please rank the following in the order which they would PREVENT you from having treatment.
___ Missing work time ___ Fear of pain ___ Lack of concern ___Cost of treatment ___ Length of treatment time

Are there any other medical/dental information or experiences you feel we should know about? _____

_____

The responses on this questionnaire are accurate to the best of my knowledge. If there is any change in my medical status I will inform the doctor.

Patient Signature or Parent/Guardian of child _____ Date: _____

Date	Medical history update changes and comments (every 6 months)	Patient signature
_____	_____	_____
_____	_____	_____
_____	_____	_____

Name _____ **DOB** _____
Last Name **First Name**

Apex Endodontics of Las Vegas is committed to providing state-of-the-art dental care at reasonable costs to our patients. Apex Endo of Las Vegas firmly believes a good doctor/patient relationship regarding financial policy is based upon clear communication and understanding. In order to achieve this, please review our financial policy.

Payment for services provided to you is ultimately your responsibility and is due at the time of service. For your convenience, we accept:

1. Cash, check, money order
2. Visa, Mastercard, American Express and Discover Card
3. Third Party Financing options through Care Credit.

We are also preferred providers for multiple insurance plans. However, insurance does not cover the total cost of dental procedure fees charged but is only designed to reduce your cost. Please keep in mind that your insurance policy is a contract between you and your insurance company. It is your responsibility to inform us in a timely manner of any changes to your billing and insurance information.

Insurance claims are filed as a courtesy to our patients and insurance coverage does not relieve the patient of financial responsibility, nor suspend payments until the insurance has paid. If an insurance company denies payment for incomplete or wrong information, it is your responsibility to make payment in full.

Once insurance benefits have been verified by our office, we will attempt to estimate the patient's out-of-pocket portion of the treatment fees. However, this is only an **ESTIMATE** and neither the insurance company nor our office can guarantee this figure. Your estimated co-insurance (out-of-pocket) payment is due in full for each visit at the time of service.

Our office will send the patient or responsible party a monthly statement showing the balance of the account in an effort to keep the patient informed of the status. We recommend that you follow-up with your insurance carrier within the first thirty (30) days and advise us if there is a problem. If no insurance payment is received within sixty (60) days of service, **the patient is fully responsible for payment of account**. Any unpaid amount not covered by your insurance must be paid by the responsible party no later than 60 days following treatment.

If payment has not been made to an account ninety (90) days after service is rendered, and no contact or appropriate arrangements have been made, the account will be referred to the necessary legal authorities, credit bureau services and collection services. A $150 fee will be applied to all accounts referred to collection services.

In cases of divorced parents, the parent bringing the child will be deemed responsible for payment.

For procedures requiring the use of the microscope-equipped room, in order to schedule the procedure and to secure your desired date, we must obtain a non-refundable deposit equivalent to your facility fee. The deposit will be applied to your total treatment cost, however if the procedure is canceled for any reason, this balance is **non-refundable** except in the case of documented emergency or medical disability.

Assignment of Benefits

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s) to issue payment check(s) directly to Apex Endodontics of Las Vegas for medical/dental services to myself and/or my dependents regardless of my insurance benefits, if any.

I have read and understand the practice's financial policy and I agree to be bound by its terms. **This signature on file is also my authorization for the release of information necessary to process any insurance claims.** I also understand and agree that such terms may be amended by the practice from time to time.

Patient/ Legal Guardian Signature_____ Date: _____

Name _____ **DOB** _____
Last Name **First Name**

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.
Purpose of consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practice before you decide whether to sign this consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent. We reserve the right to change our privacy practices as described in our Notice of Privacy Practice. If we change our privacy practice, we will issue a revised Notice of Privacy Practice, which will contain the changes. Those changes may apply to any of your protected health information that we maintain. You may obtain a copy of our Notice of Privacy Practice, including any revisions of our Notice, at anytime by contacting:

Contact Person: Dr. Eddie Tai Telephone: 702.723.9808 Fax: 702.723.9818

E-mail: eddietaidmd@apexendolv.com Address: 2337 E Bonanza Road, Las Vegas, NV 89101

Right to Revoke: You will have the right to revoke this Consent at anytime by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

Release medical information to the following people (other than referring doctor and insurance company):

Name_____ Phone Number _____

Name_____ Phone Number _____

Name_____ Phone Number _____

Acknowledgment

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that by signing this Consent form, I am giving my consent to your use and disclosure of protected health information to carry out treatment, payment activities, and healthcare operations. I am placing the following restrictions on this consent: _____

Signature: _____ Date: _____

If a personal representative on behalf of the patient is signing this Consent, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT