Samuel H. Savage, D.D.S. Cosmetic, General, & Implant Dentistry

Patient Information

Patient name _____ DOB _____ Date _____

Sex ☐ Male ☐ Female Preferred name _____ SSN/SIN _____

Home phone (___) ___-____ Cell phone (___) ___-____ Work phone (___) ___-____

Email _____ Who can we thank for referring you? _____

Address _____ City _____ State _____ Zip_____

Check appropriate box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

*Emergency contact _____ Relation _____ Phone (___) ___-____

*Emergency contact _____ Relation _____ Phone (___) ___-____

In case of a medical emergency, if the patient is of school age 15+, it is all right to treat in my absence.

X_____ _____

Parent or guardian signature Date

Responsible Party

Name of person responsible for this account _____

Relation _____ SSN/SIN _____

Home phone (___) ___-____ Cell phone (___) ___-____ Work phone (___) ___-____

Billing address _____ City _____ State _____ Zip_____

Email _____ Is this person currently a patient at our office? ☐ Yes ☐ No

Insurance Information

Insurance Company _____ Phone (___) ___-____

Subscriber Name _____ ID# _____ DOB _____

Group # _____ Group Name _____

INS address _____ City _____ State _____ Zip_____

Do you have additional insurance? ☐ Yes ☐ No If yes, complete the following:

Insurance Company _____ Phone (___) ___-____

Subscriber Name _____ ID# _____ DOB _____

Group # _____ Group Name _____

INS address _____ City _____ State _____ Zip_____

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Dental Health History

Patient name _____ DOB _____ Date _____

Reason for this visit _____

Date of last exam _____ Cleaning _____ Xrays _____

How often did you visit the dentist before then? _____

Previous dentist (Name and location) _____

How often do you brush your teeth? _____ How often do you floss? _____

	YES	NO
My gums bleed while brushing or flossing……..	☐	☐
My teeth are sensitive to hot or cold..	☐	☐
My teeth are sensitive to sweet or sour……	☐	☐
I feel pain in one/some of my teeth…	☐	☐
I have sores/ lumps in or near my mouth……...	☐	☐
I have had head, neck, or jaw injuries……...	☐	☐
I have experienced these problems with my jaw		
Clicking……..	☐	☐
Pain (joint, ear, side of face)..	☐	☐
Difficulty in opening/closing…	☐	☐
Difficulty in chewing…….....	☐	☐
I have frequent headaches…..……	☐	☐

	YES	NO
I clench/grind my teeth…….	☐	☐
I bite my lips/cheeks frequently……	☐	☐
I have noticed loosening of my teeth	☐	☐
Food tends to get caught between my teeth ……	☐	☐
I have had periodontal treatment (gums)……..	☐	☐
I have worn a bite plate or another appliance……...	☐	☐
I have had difficult extractions in the past……...	☐	☐
I have had prolonged bleeding following extractions……	☐	☐
I wear dentures or partials……	☐	☐
If yes, date of placement_____		
I have received oral hygiene instructions regarding the care of my teeth and gums……	☐	☐

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers 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.

X_____ _____

Patient/Guardian Signature Date

Patient # _____

Medical Health History

Patient name _____ DOB _____ Date _____

General Health Questions

	YES	NO
1. Are you in good health……..	☐	☐
2. Have there been any changes in your general health within the past year……..	☐	☐
3. Date of your last physical exam _____		
4. Physician's name _____ Address _____ Phone (_ _) _ _ -_____		
5. Are you now under the care of a physician……..	☐	☐
6. Have you ever been hospitalized for any surgical operation or serious illness……..... Please explain_____ _____ _____	☐	☐
7. Are you taking any medicine(s).....	☐	☐
Including ones not prescribed……..	☐	☐
If yes, list which medicine(s) you are taking _____ _____ _____ _____ _____ _____		
8. Have you had any abnormal bleeding ……..	☐	☐
9. Do you bruise easily……..	☐	☐
10. Have you ever required a blood transfusion.....	☐	☐
11. Are you taking blood thinners……..	☐	☐

	YES	NO
12. Does your physician require you to take any antibiotics before dental treatment……..	☐	☐
13. Have you had a recent weight loss……..	☐	☐
14. Have you ever taken FEN-PHEN/REDUX……..	☐	☐
15. Do you use tobacco……..	☐	☐
16. Do you or have you used controlled substances……..	☐	☐
17. Are you wearing contact lenses……..	☐	☐
18. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)……..	☐	☐
19. Do you have any disease, condition or problem not listed above that you think I should know about……..	☐	☐

Women only:

Are you pregnant or think you may be pregnant……..	☐	☐
Are you nursing……..	☐	☐
Are you taking birth control pills……..	☐	☐

Are you allergic to or have had reactions to:

Local anesthetics like Novocaine……..	☐	☐
Penicillin or other antibiotics……..	☐	☐
Sulfa drugs……..	☐	☐
Barbiturates, sedatives or sleeping pills.....	☐	☐
Aspirin……..	☐	☐
Iodine……..	☐	☐
Any metals (e.g. nickel, mercury, etc.)…..	☐	☐
Latex/rubber……..	☐	☐
Other_____		

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Patient name _____ DOB _____ Date _____

Do you have or had the following:

	YES	NO
Rheumatic heart disease or rheumatic fever	☐	☐
Scarlet fever	☐	☐
Heart defect or heart murmur	☐	☐
Heart trouble, heart attack or angina	☐	☐
Chest pain	☐	☐
Shortness of breath	☐	☐
Pacemaker	☐	☐
Heart surgery	☐	☐
High blood pressure	☐	☐
Low blood pressure	☐	☐
Congenital heart problem	☐	☐
Swelling of feet, ankles, hands	☐	☐
Hepatitis, jaundice or liver disease	☐	☐
Stroke	☐	☐
Sinus trouble	☐	☐
Lung or breathing problems	☐	☐
Asthma or hay fever	☐	☐
Hives or skin rash	☐	☐
Fainting or dizzy spells	☐	☐
Diabetes	☐	☐
AIDS or HIV infection	☐	☐
Thyroid problems	☐	☐
Allergies	☐	☐
Arthritis or rheumatism	☐	☐
Joint replacement or implant	☐	☐
Stomach ulcer	☐	☐
Kidney trouble	☐	☐

	YES	NO
Tuberculosis	☐	☐
Cough that produces blood	☐	☐
Chemotherapy (cancer, leukemia)	☐	☐
Radiation treatment	☐	☐
Sexually transmitted disease	☐	☐
Epilepsy or seizures	☐	☐
Anemia	☐	☐
Glaucoma	☐	☐
Nervousness	☐	☐
Tonsillitis	☐	☐
Tumors	☐	☐
Mental health care	☐	☐
Back problems	☐	☐
Chemical dependency	☐	☐
Mitral valve prolapsed	☐	☐
Cortisone treatment	☐	☐
Cold sores/ fever blisters	☐	☐
Hypoglycemia	☐	☐
Eating disorders	☐	☐

Patient # _____

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Cosmetic, General, & Implant Dentistry

Patient's Name: _____Patient #_____DOB_____

Please take a moment to tell us about your smile so that we may better serve your individual needs

WHEN I SEE A PICTURE OF MYSELF, THE FIRST THING I NOTICE ABOUT MY SMILE IS:

_____

SOME THINGS THAT I CONSIDER ATTRACTIVE IN OTHER PEOPLE'S SMILES ARE:

_____

****Please "√" the statements below that apply to you.**

- o I wish my teeth were straighter.
- o I wish I had a broader smile.
- o I think some of my teeth are too small.
- o I think some of my teeth are too large.
- o I wish my teeth were whiter with regard to their color
- o I think my gums show too much when I smile.
- o I think my smile shows too much space between some of my teeth.
- o Because I am not totally pleased with my teeth, I sometimes hesitate to smile.
- o I feel as though I don't really know all of the options available to me for enhancing my smile.
- o Concerns over what the end result might look like have been a factor in my not having aesthetic dentistry in my mouth.
- o Concerns over fees have prevented me from taking advantage of some of the available options to enhance my smile.
- o I feel as though I could do a better job protecting the health of my teeth and gums, and therefore, the longevity of my smile.

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www.drsavagedental.com

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Written Financial Policy

Thank you for choosing Samuel H. Savage DDS. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:

You can choose from:

- Cash, Check, Visa, MasterCard, American Express or Discover Card

  We offer a 5% courtesy accounting adjustment to patients who pay for their treatment in full with cash or check on or prior to starting treatment.

- Convenient Monthly Payment Plans[1] from CareCredit
  - Allow you to pay over time
  - No annual fees or pre-payment penalties

Please note:

Our office requires your estimated patient portion to be paid prior to completion of your treatment.

For plans requiring multiple appointments, alternative payment arrangements may be provided. For larger treatment plans a 50% deposit is required to secure your initial treatment appointment.

We will do our best with the **estimated** coverage to calculate your portion due for treatment and that portion is due in full at the time treatment is provided. **If there is any balance remaining after your insurance pays, you will be responsible for the remainder.**

There is a charge $25 for returned checks.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

_____

Patient, Parent or Guardian Signature Date

_____

Patient Name (Please Print)

[1]Subject to credit approval

SAMEUL H. SAVAGE, D.D.S.

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Patient Number: _____ Social Security Number: _____

SECTION B: TO THE PATIENT—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 Practices 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 Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, 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 Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: SAMUEL H. SAVAGE, D.D.S._____

Telephone: (702)734-1100_____ Fax: (702)734-7899_____

E-mail: _____

Address: 223 N PECOS RD #130 HENDERSON, NV 89074_____

Right to Revoke: You will have the right to revoke this Consent at any time 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.

SIGNATURE

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 my protected health information to carry out treatment, payment activities and heath care operations.

Signature: _____ Date: _____

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

Personal Representative's Name: _____

Relationship to Patient: _____

SAMUEL H. SAVAGE, D.D.S.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
{Please Print Name}

_____
{Signature}

_____
{Date}

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____