256 E. Lake Mead Parkway, Suite C | Henderson, NV 89015 | (702) 703-5410 | sunrisemountaindental.com | smile@sunrisemountaindental.com

Patient Information

Last Name: ___________________________ First Name: ___________________________ Middle Initial: _________

Gender: M / F Date of Birth: ___________________________ SSN: ___________________________ Married: Y / N

Street Address: ____ City:_______________ St: ______ Zip:_________

Email: ____ Primary Phone: ___________________________

Employer Name: ___________________________ Employer Phone: ___________________________

Emergency Contact: ___________________________ Emergency Phone: ___________________________

How did you hear about our office? ____

What school do you attend?____

Responsible Party

If the patient is under 18 year old, please complete the following:

Last Name: ___________________________ First Name: ___________________________ Middle Initial: ________

Date of Birth: ___________________________ Gender: M / F Married: Y / N SSN: ___________________________

Email Address (if different from above):____

Primary Phone Number:_________________________________

Insurance Information

Patient Relationship to Subscriber: { } Self { } Spouse { } Child

Subscriber Name: ___________________________ Subscriber ID: ___________________________

Insurance Company: ______________________________ Subscriber SSN: ____________________ DOB:_________________

Employer: ___________________________ Group Name: ___________________________ Group #:_____________________

Insurance Phone Number: ___________________________

Secondary Coverage:

Patient Relationship to Subscriber: { } Self { } Spouse { } Child

Subscriber Name: ___________________________ Subscriber ID: ___________________________

Insurance Company: ______________________________ Subscriber SSN: ____________________ DOB:_________________

Employer: ___________________________ Group Name: ___________________________ Group #:_____________________

Insurance Phone Number: ___________________________

Signature: ____ Date: _________________________

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ACKNOWLEDGEMENT OF RECIEPT OF NOTICE OF PRIVACY PRACTICES

(You may refuse to sign the Acknowledgement)

I have received/ was offered a copy of this office's Notice of Privacy Practices.

Print Name: ____

Signature: ____

Date: ____

I authorize Sunrise Mountain Dental & Orthodontics to discuss and/ or release my medical information including labs and test results, diagnosis and treatments discussed to the following individuals. Also, I authorize Sunrise Mountain Dental & Orthodontics to discuss my account information including account balances, insurance information, statements, and payment options to the same persons.

Name: ___________________________ Relationship to Patient: ___________________________

Name: ___________________________ Relationship to Patient: ___________________________

Name: ___________________________ Relationship to Patient: ___________________________

Name: ___________________________ Relationship to Patient: ___________________________

Name: ___________________________ Relationship to Patient: ___________________________

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Assignment of Benefits

Financial Responsibility : I understand that insurance billing is a service provided as a courtesy and that I am at all times financially responsible to Sunrise Mountain Dental & Orthodontics and/or its affiliated entities for any charges not covered by dental benefits. It is my responsibility to notify Sunrise Mountain Dental & Orthodontics of any changes in my dental coverage. In some cases exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by Sunrise Mountain Dental & Orthodontics and/or my dental insurer if the submitted claims or any part of them are denied for payment. I understand that by signing this form, that I am accepting financial responsibility as explained above for all payments for dental services and/or supplies received.

Assignment of Benefits : I authorize direct remittance of payment of all insurance benefits, including Medicare, if I am a Medicare beneficiary, to Sunrise Mountain Dental & Orthodontics for all covered dental services and supplies provided to me during all courses of treatment and care provided by Sunrise Mountain Dental & Orthodontics and/or its affiliated entities or otherwise at its direction. I understand and agree this Assignment of Benefits will have continuing effects for as long as I am being treated or cared for by Sunrise Mountain Dental & Orthodontics, and will continue a continuing authorization, maintained on file with Sunrise Mountain, which will authorize and allow for direct payment to Sunrise Mountain of all applicable and eligible insurance benefits for all subsequent and continuing treatment, services, supplies and/or care provided to me by Sunrise Mountain Dental & Orthodontics.

Authorization to Release Information : I authorize the release of any medical or dental information to the Health Care Financing Administration, my insurance carrier(s), or other entity necessary to determine insurance benefits of the benefits payable for related dental services and/or supplies provided to me by Sunrise Mountain. A copy of this authorization will be sent to the Health Care Financing Administration, my insurance carrier(s), or other dental entity, if requested. The original authorization will be kept by Sunrise Mountain Dental & Orthodontics.

Benefits or Orthodontics : I understand that my diagnostic records - my name and photos may be used for educational and promotional purposes. I have truthfully answered all of the above questions and agree to inform this office of any changed in my medical or dental history. In addition, I authorize Sunrise Mountain Dental & Orthodontics to perform a complete dental orthodontic evaluation.

Signature (parent or guardian) : ____

Date : ______________________________

Name of Patient : ____

Relationship to Patient : _________________________________

SUNRISE MOUNTAIN
DENTAL & ORTHODONTICS

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Medical History

Name of Patient: ____________________________________

Name of Medical Doctor: ______________________________ Contact Number: ______________________________

Address: ____

List of any medications: { } NONE

____

____

____

____

____

Check Medications you are allergic to: { } NONE

{ } Aspirin
{ } Local Anesthetics
{ } Codeine/ other Narcotics
{ }Metals
{ } Erythromycin
{ } Penicillin
{ } Latex Rubber
{ } Sulfa Drugs
{ } Other: ______________________________

Check any medical conditions you may have:

{ } NONE	{ } Blood Transfusion	{ } Epilepsy	{ } Heart Murmur
{ } AIDS/ HIV	{ } Bronchitis	{ } Fainting Spells/ Seizures	{ } Hepatitis/ Jaundice
{ } Alcohol/ Drug Abuse	{ } Cancer/ Tumor or Growth	{ } Fever Blisters/ Herpes	{ } High Blood Pressure
{ } Anemia/ Leukemia	{ } Cardiac Pacemaker	{ } Frequent Headaches	{ } Hives/ Sin Rash
{ } Anorexia/ Bulimia	{ } Chest Pain upon Exertion	{ } Frequent Dry Mouth	{ } Joint Replacement
{ } Arthritis	{ } Damaged Heart Valve	{ } Gall Bladder Trouble	{ } Kidney/ Bladder Trouble
{ } Asthma/ Hay Fever	{ } Diabetes	{ } Heart Attack/ Stroke	{ } Liver Disease
{ } Blood Clotting Problems	{ } Emphysema	{ } Heart Disease/ Angina	{ } Low Blood Pressure
{ } Mental Health Problems	{ } Rheumatic Fever	{ } Sinus Trouble	{ } Thyroid Problems
{ } Mitral Valve Prolapse	{ } Rheumatic Heart Disease	{ } Sleep Apnea/ CPAP	{ } Tuberculosis
{ } Persistent Diarrhea	{ } Sexually Transmitted Disease	{ } Stomach Ulcers	

{ } Other : ____

Are you taking, or have taken, *Bisphosphonates* (e.g. *Fosomax*) for osteoporosis? Y / N

Tobacco use? Y / N if so, what kind & how much? ____

Unusual reaction to dental injections? Y / N ____

Have you had any major operations? Y/ N ____

Have you ever been involved in a serious accident? Y/ N ______________________________________

Has tonsils & adenoids been removed? Y / N What age? ____________________

Women: Are you pregnant? Y / N Are you on birth control? Y / N

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Dental Health

Name of Patient: ____

Reason for today's visit: ______________________________________

Are you in any pain? Y / N

Date of last dental visit: __________________Treating Dentist?_______________________

Do you have your wisdom teeth? Y / N Are you missing any teeth? ________________________

What concerns you most about your teeth? ____

How happy are you with your smile? *Not Happy* 1 2 3 4 5 6 7 8 9 10 *Very Happy*

Do your gums bleed? Y / N Have you ever been diagnosed with sleep apnea? Y / N

Has there been any injuries to your face, mouth, or teeth? Y / N _________________________________

Do you have any thumb or tongue habits? Y / N _______________________________________

Has an orthodontist been consulted previously? Y / N ___________________________________

Are you okay with wearing orthodontic appliances, should they be recommended? Y / N ________________

Do your teeth or jaw ever feel uncomfortable when you wake up in the morning? Y / N ________________

Are you aware of your jaw clicking or popping? Y / N ___________________________________

Have you ever been told that your grind your teeth? Y / N ________________________________

Are you aware that some appointments may be during work/school hours? Y / N

By signing below, I certify that all of the above information is true to the best of my knowledge:

Signature ____

Printed Name ____

Relationship to the Patient __________________________________

Date _______________________________

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Notice of Privacy Practices

This notice describes how your health information may be used and disclosed and how you can get access to this information. Please review carefully. The privacy of your health information is important to us.

Our Legal Duty

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this notice while it is in effect.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this notice and make the new notice available upon request. You may request a copy of our notice at any time.

For more information about our privacy practices, or for additional copies of this notice, please contact us according to the means outlined in this notice.

Uses and Disclosures of Health Information

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

- Treatment: We may use or disclose your health information to a physician/ dentist or other healthcare provider providing treatment to you.
- Payment: We may use and disclose your health information to obtain payment for services we provide to you.
- Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.
- Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect . Unless you give us a written authorization we cannot use or disclose your health information for any reason except those described in this notice.
- To your Family & Friends: We must disclose your health information to you, as described in the Patient Rights section of this notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.
- Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up prescriptions, dental supplies, x-rays, or other similar forms of health information.
- Marketing Health Related Services: We will not use your health information for marketing communications without your written authorization.
- Required by Law: We may use or disclose your health information when we are required to do so by law.
- Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to

avert a serious threat to your health or safety or the health or safety of others.

- **National Security**: We may disclose to military authorities that health information of Armed Forces personnel under certain circumstances. We may disclose, to authorized federal officials, health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institutions or law enforcement officials having lawful custody of protected health information or inmate or patient under certain circumstances.
- **Appointment Reminders**: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, letters, or text messages).

Patient Rights

- **Access:** You have the right to look at or get copies if your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. If you request copies, we will charge a fee for copies of your x-rays and of your dental record and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee.
- **Disclosure Accounting:** You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.
- **Restriction:** You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).
- **Alternative Communication:** You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. This request must be in writing. Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.
- **Amendment:** You have the right to request that we amend your health information. This request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances.
- **Electronic Notice:** If you received this notice on our Website or by electronic mail (e-mail), you are also entitled to receive this notice in written form.

Questions and Concerns

If you would like additional information about our privacy practices or have questions, please ask for the Office Manager.

If you are concerned that we may have violated your privacy rights, or if you disagree with a decision we made about access to your health information or our handling of your response to a request you made to amend or restrict the use or disclosure of your health information, or to have us communicate with you by alternative means or at alternative locations, you may send your concerns to Cody Johnson DDS, Attn: HIPAA Compliance, 256 E. Lake Mead Parkway Suite C, Henderson NV 89015. You also may submit written concerns to the U.S. Department of Health and Human Services.

We support your right to maintain the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.