Welcome to Our Office!
Dr. Elizabeth Park
501 S. Division Street Carson City NV 89703
775-882-1195

Patient Name _____ D.O.B _____ SS#_____

Home Address _____ City_____ Zip_____

Mailing Address (If Different) _____

Email Address _____

Home Phone_____ Work _____Cell _____

Employer_____ Position_____

List any family members who have or are patients at this office_____

How did you hear about us?_____

Emergency Contact _____ Phone _____

Patient/Guardian/ Responsible Party of Patient

Name_____ Relationship to patient _____

Address _____ Phone _____

Email _____ D.O.B. _____ SS#_____

Primary Insurance

Employer _____ Insurance Company _____

Group # _____ ID#_____

Name of policy holder _____DOB_____ SS#_____

Secondary Insurance

Employer _____ Insurance Company _____

Group # _____ ID#_____

Name of policy holder _____DOB_____ SS#_____

1) The undersigned hereby authorizes the doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis of the patient's dental needs.
2) I also authorize the doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment in connection with (Patient Name) _____. I understand that using anesthetic agents embody a certain risk. Furthermore, I authorize and consent that the doctor choose and employ such assistance as deemed fit to provide recommended treatment.
3) I Understand that it is my responsibility to advise your office of any changes in the information contained in this form.

Print Name_____ Date _____

Sign Name _____ Relationship to patient_____

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Are you having any problems with (circle)

Headaches Difficulty Chewing Pain in/around ears Pain Opening/Closing mouth

Are you awake of any swelling/lumps in your mouth? _____ Y N

Are you in good health? _____ Y N

Physician _____ Phone_____ Last Physical _____

Are you in physicians care now? _____ Y N

If yes, for what? _____

Have you ever had a serious injury, illness, or operation? _____ Y N

Have you ever been hospitalized? _____ Y N

If yes, for what?_____

Are you taking any drugs or medication? _____ Y N

If yes, for what? _____

Are you sensitive or allergic to any drugs?_____ Y N

If yes, what? _____

Are you allergic to LATEX? _____ Y N

Do you have, or ever had any of the following? (if YES, circle)

Anemia Stomach Ulcer Glaucoma Hepatitis, Jaundice, or Live Disease

Heart Problems Kidney Disease Sinus Trouble Difficulty Swallowing Epilepsy Stroke

Diabetes Rheumatism or Arthritis Herpes Blood Disorders Sleep Disorder

Fainting Spells or Seizures Rheumatic Fever Excessive Bleeding Mental Disorders

Acquired Immune Deficiency Tuberculosis Snoring Daytime Sleepiness

Tumors/Growths Venereal Disease Use tobacco High Blood Pressure

Artificial Prosthesis (Implant) Allergies Night Sweats Gasping for Breath

Radiation Treatment Nervous Disorders Asthma/Hay Fever Respiratory Problems

1+ Alcoholic Drinks per day

Have you had heart surgery? _____ Y N

Do you have any disease, condition, or problem not listed that you think I should know about?____ Y N

If YES, what? _____

Have you had any joint replacement? _____ Y N

If YES, when? _____ When? _____

Do you need to take ANTIBIOTICS before dental appointments? _____ Y N

Have you ever taken an appetite suppressant? Fenfluramine/phentermine or Desfenfluramne (FenFen/Redux) Y N

(Women) Are you pregnant?_____ Y N

If YES, how many months? _____

(Women) Do you have any menstruation problems? _____ Y N

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

Park Dental Management Company
501 S. Division Street
Carson City, NV 89701
(775)882-1195

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

- ☐ Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly
- ☐ Obtain payment from third-party payers for my health care services
- ☐ Conduct normal health care operations such as quality assessment and improvement activities

I have been informed of my dental provider's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices*. I understand that my dental provider has the right to change the *Notice of Privacy Practices* and that I may contact this office at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____ Date: _____

Signature: _____

Relationship to Patient: _____

Dependent family members also covered by this acknowledgement:

_____

_____

For Office Use Only:

We were unable to obtain the patient's written acknowledgement of our Notice of Privacy Practices due to the following reason:

- ☐ The patient refused to sign
- ☐ Communication barriers
- ☐ Emergency situation
- ☐ Other

Park Dental Management --- Elizabeth Park DDS

Financial Policy

1. When insurance is not involved, payment is due in FULL at time of service.

2. If you have dental insurance you will need to pay your yearly deductibles as well as your estimated co pay at the time of service.

3. We will bill your insurance as a courtesy only. If your insurance has not paid within 30 days, it is YOUR responsibility to contact your insurance to ensure the payment Is processed. You can also pay your account in full and wait to be reimbursed.

4. If your account becomes 60 days delinquent, Park Dental Management will assign your account to a collection agency. If assigned to a collection agency, your delinquent amount will be charged an additional 50% to cover their commission.

5. I understand that this office's standard for exam and x-rays is every 12 months.

I understand the statements I have just read.

_____

Sign Name

_____ _____

Print Name Date

Park Dental Management Company

Missed Appointment Policy

A missed appointment is defined as an appointment that you do not show up for or an appointment that you provide less than 48-hour notice to cancel or reschedule.

Please **CONFIRM** your appointment

We will contact you prior to your appointment via phone, email or text. You must reply to one of these contacts to confirm your appointment. It is as easy as replying to the text message '**C**' to confirm. Please note-- you can also leave us a voicemail if it is after normal business hours and you need to cancel, reschedule, or confirm keeping in mind the 48 hour policy.

If you have not confirmed your appointment 48 hours prior to your appointment, we reserve the right to reschedule you.

Late Arrivals

Please keep in mind that we maintain a full schedule. Even one patient running late can impact the office. Please call to let us know if you are running late so we can manage accordingly or possibly reschedule.

There is a **$55** no call no show fee/less than 48 hour notice of cancelation.

_____	_____	_____
Patient Name	Signature	Date