# PATIENT INFORMATION

(PLEASE PRINT) DATE_____

NAME_____
LAST FIRST MIDDLE PREFERRED

CHECK WHERE APPLICABLE: MALE___ FEMALE___; SINGLE___ MARRIED___ CHILD___

DATE OF BIRTH _____ SOC SEC #_____

ADDRESS_____CITY_____ST_____ZIP_____

EMAIL _____REFERRED BY_____

PHONE #: HOME_____ WORK _____CELL_____

EMPLOYER_____ POSITION_____

IN CASE OF EMERGENCY CONTACT_____ PHONE_____

RELATIONSHIP TO PATIENT_____

OFFICE OPENS AT 7:00AM, MAY WE CONTACT YOU BEFORE 9:00AM? YES___ NO___

PATIENT/RESPONSIBLE PARTY SIGNATURE _____
**(You must sign here if you are 18yrs or older)**

## INSURANCE INFORMATION

NAME OF INSURED_____ADDRESS_____

RELATION TO PATIENT _____HOME PHONE_____ DATE OF BIRTH_____

SOC SECURITY #_____ EMPLOYER _____ WORK PHONE _____

INSURANCE CO_____ GROUP # _____ INS PHONE #_____

DO YOU HAVE SECONDARY INSURANCE? YES___ NO___

NAME OF INSURED_____ADDRESS_____

RELATION TO PATIENT _____HOME PHONE_____ DATE OF BIRTH_____

SOC SECURITY #_____ EMPLOYER _____ WORK PHONE _____

INSURANCE CO_____ GROUP # _____ INS PHONE #_____

**ASSIGNMENT AND RELEASE:**

I, the undersigned, certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr. Richard W. Featherstone all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____

**Responsible Party Signature (You must sign here if you are 18yrs or older)** **Date**

# DENTAL AND MEDICAL HEALTH HISTORY

| Caries (Cavities) | | | TMD (Jaw Motion Disease) | | | Gum Disease (Periodontal) | | |
|---|---|---|---|---|---|---|---|---|
| Fillings in last 3yrs | Y | N | Clicking/Popping of Jaw | Y | N | Bad breath | Y | N |
| Frequent soda or juices | Y | N | Jaw pain or tiredness | Y | N | Loose teeth | Y | N |
| Frequent snacking | Y | N | Pain around ear | Y | N | Gums swollen/tender | Y | N |
| Recreational drug use | Y | N | Edges of teeth worn/uneven | Y | N | Red/bleeding/swollen gums | Y | N |
| Dry Mouth | Y | N | Difficulty opening wide | Y | N | Cigarette or pipe smoking | Y | N |
| Receded gums | Y | N | Grinding teeth | Y | N | Periodontal scaling/surgery | Y | N |
| Sensitivity to cold/heat | Y | N | Difficulty chewing gum | Y | N | Food packs between teeth | Y | N |
| Sensitivity when biting | Y | N | Difficulty chewing hard foods | Y | N | Crooked/crowded teeth | Y | N |
| Brush less than 2x a day | Y | N | Teeth shorter/thinner last 5yrs | Y | N | Brush less than 2x a day | Y | N |
| Floss less than1x a day | Y | N | Teeth crowding or spacing | Y | N | Floss less than1x a day | Y | N |
| Use fluoridated water | Y | N | More than one bite | Y | N | **Other:** | | |
| Use fluoride Rinse | Y | N | Teeth only fit when clenched | Y | N | Mouth blisters/sores/growth: | Y | N |
| Rec in office fluoride 6mo | Y | N | Wake up aware of teeth/jaw | Y | N | If other what:_____ | | |
| Use protective products | Y | N | Frequent headaches | Y | N | Smoke:_____ Pack(s) Per: _____ | | |

Former Dentist & address: _____

Physician Name, Phone & Date of last visit: _____

Reason for today's visit? _____

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| AIDS/HIV | Y | N | Epilepsy | Y | N | Radiation treatment | Y | N |
| Anemia | Y | N | Fainting or dizziness | Y | N | Respiratory disease | Y | N |
| Arthritis, rheumatism | Y | N | Glaucoma | Y | N | Rheumatic fever | Y | N |
| Artificial heart valves | Y | N | Headaches | Y | N | Scarlet fever | Y | N |
| Artificial joints | Y | N | Heart murmur | Y | N | Shortness of breath | Y | N |
| Asthma | Y | N | Heart problems | Y | N | Sinus trouble | Y | N |
| Back problems | Y | N | Heart stents | Y | N | Skin rash | Y | N |
| Bleed abnormally | Y | N | Hepatitis type: _____ | Y | N | Stroke | Y | N |
| Blood disease | Y | N | Herpes | Y | N | Swelling of feet or ankles | Y | N |
| Cancer | Y | N | High blood pressure | Y | N | Swollen neck glands | Y | N |
| Chemical dependency | Y | N | Jaundice | Y | N | Thyroid problems | Y | N |
| Chemotherapy | Y | N | Jaw pain | Y | N | Tonsillitis | Y | N |
| Circulatory problems | Y | N | Kidney disease | Y | N | Tuberculosis | Y | N |
| Congenital heart lesions | Y | N | Liver disease | Y | N | Tumors or growths | Y | N |
| Cortisone treatments | Y | N | Low blood pressure | Y | N | Ulcer | Y | N |
| Cough, persistent/bloody | Y | N | Mitral valve prolapse | Y | N | Venereal disease | Y | N |
| Diabetes | Y | N | Nervous problems | Y | N | Wear contact lenses | Y | N |
| Emphysema | Y | N | Pacemaker | Y | N | Weight loss, unexplained | Y | N |

**ALLERGIES:**

| | | | | | |
|---|---|---|---|---|---|
| Aspirin | Y | N | Local Anesthetic | Y | N |
| Barbiturates | Y | N | Penicillin | Y | N |
| Codeine | Y | N | Sulfa | Y | N |
| Iodine | Y | N | Latex | Y | N |
| Clyndamycin | Y | N | Ibuprofen | Y | N |

**MEDICATIONS:** Please list all medications you are currently taking, the dosage and the correlating diagnosis.

**Have you ever taken Bisphosphonates?** Y N

Pharmacy Name & phone number: _____

**Women:**

Nursing or pregnant? Y N On birth control Y N

_____ _____

Responsible party signature (you must sign here if you are 18 or older) Date

_____ _____

Provider's Signature Date

**Richard W. Featherstone, DDS, LLP**
**880 Seven Hills Drive #130**
**Henderson, NV 89052**
**(702)914-4478**

# SMILE EVALUATION

1. **Do you like the way your teeth look? Yes No (circle one)**
   **Explain: _____**

2. **Are you happy with the color of your teeth? Yes No**
   **Explain: _____**

3. **Would you like for your teeth to be whiter? Yes No**
   **Explain: _____**

4. **Would you like your teeth to be straighter? Yes No**
   **Explain: _____**

5. **Do you have spaces between your teeth that you would like closed? Yes No**
   **If so, where? _____**

6. **Would you like your teeth to be longer? Yes No**
   **If so, Upper____ Lower____ Both____?**

7. **Do you like the shape of your teeth? Yes No**
   **Explain: _____**

8. **Do you have missing teeth that you would like to replace? Yes No**
   **Explain: _____**

9. **Do you have old silver fillings that you would like to replace with tooth-colored fillings? Yes No**
   **Explain:_____**

10. **If you could change anything about your smile, what would you change?**
    **_____**
    **_____**
    **_____**

_____
Signature (Patient/Guardian)

_____ _____
Patient Name Date

**Richard W. Featherstone, DDS, LLP**
**880 Seven Hills Drive #130**
**Henderson, NV 89052**
**702-914-4478**

# CONSENT FOR TREATMENT

_____I the undersigned hereby authorize Doctor Featherstone to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the Doctor's to make a thorough diagnosis of my dental needs. I also authorize Doctor Featherstone to perform any and all forms of treatment, medication and therapy that may be indicated in connection with my dental care. I am requesting that Doctor or his representative explain treatment needed. I further authorize and consent that Doctor Featherstone choose and employ such assistance as deemed fit. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made.

_____I understand that it is my responsibility to make appointments for treatment and hygiene to have the procedures completed in a timely and routine manner. If I elect to have partial treatment, no treatment or appoint outside the recommended time frame, I hereby release Dr. Featherstone from any responsibility associated with complication as a result of my decision. I further understand that any fees quoted are subject to change if additional procedures are required.

Patient_____

Responsible Party Signature_____
(You must sign here if you are 18yrs or older)

Relationship to Patient_____ Date_____

# Richard W. Featherstone, DDS, LLP
# 880 Seven Hills Drive #130
# Henderson, NV 89052

## FINANCIAL POLICY

_____Payment is due in full at the time of treatment. We accept; **Cash, Personal Checks, Third Party financing, MasterCard, Visa, American Express, or Discover.** Monthly Payment options are available upon approval with a third party dental financer. All emergency dental services and any dental services performed without previous financial arrangements must be paid for in cash at the time services are rendered.

_____All accounts outstanding more than 60 days will be assessed a finance charge of 1½% (18% annually) including those pending insurance. Any accounts that fall into default status will be sent to IC Systems collection agency and a 35% collections fee added to the principal amount due.

_____We give you our best efforts to be on time for your appointments. By signing below you agree to pay a fee of $30.00 per ½ hour for failure to appear to your appointment without a 48 hour notice. Notice consists of a telephone call during office hours. Monday through Thursday, 7am- 4pm. Messages left after hours are not considered as notice.

_____In the event of a returned check for any reason accounts will be charged a $25.00 fee or should the account default the responsible party will be asked to pay any court cost, collection or attorney fees in addition to the amount found due on the principal and interest.

## ATTENTION INSURED PATIENTS

- The estimated co-payment is due in full on the day of service. Co-payments quoted are only an estimate.
- The patient/guardian is responsible for the entire amount of all services performed. As a courtesy we will submit the claim and then collect any further amount (if any) not covered.
- Your insurance policy is an agreement between you and your insurance company, it is your responsibility to know and understand the terms and conditions of your plan. As a courtesy we will verify and process insurance claims on your behalf. Our office gathers as much information as possible from your insurance company however; we are not responsible for anything that is not disclosed to us by your insurance carrier.
- Your insurance company does not guarantee the information they give us when we verify your coverage therefore we cannot guarantee insurance coverage, payments or estimated benefits quoted.
- If you have any questions regarding your insurance coverage please contact your Human Resources department or insurance carrier directly.
- It is the patient/guardians responsibility to notify our office of any changes to your insurance coverage prior to the appointment. We are not responsible for any misquoted estimates due to changes in insurance that we are not aware of.
- Pre-estimates (Pre-Authorizations) are <u>only</u> done when your insurance company policy "Requires" them, or when the patient asks for one to be done in prior to services being rendered. Pre-estimates are <u>not</u> a guarantee of payment or coverage and are not guaranteed to be accurate by the insurance company.

____ I have been given the opportunity to ask questions after reading and prior to signing; I understand and will comply with the policies described above.

Patient: _____ Date_____

Patient/Responsible Party Signature: _____
(The patient must sign here if you are 18 years or older)

Relationship to patient: _____

# Consent for Internet Communications

Patient Name: _____

I grant my permission to the dental practice to upload and store confidential patient information (including account information, appointment information and clinical information) to the secured web site for the dental practice. I understand that, for security purposes, the site requires a user ID and password for access and use. I also understand the dental practice and I are responsible for maintaining the strict confidentiality of any ID and password assigned to me; and that the dental practice is not liable for any charges, damages, or losses that may be incurred or suffered as a result of my failure to maintain confidentiality. I understand the dental practice is not liable for any harm related to the theft of my ID and password, my disclosure of my ID and password, or my authorization to allow another person or entity to access and use the dental practice web site with my ID and password. I also agree to immediately notify the dental practice of any unauthorized use of my ID or of any other need to deactivate my ID due to security concerns.

I also understand that State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I understand the dental practice will represent and warrant that they will, at all times during the terms of this Agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that the dental practice has the right to monitor, retrieve, store, upload and use my information in connection with the operation of such services, and is acting on my behalf in uploading my patient information. I understand the dental practice will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the web site on my behalf. I understand the dental practice CANNOT AND DOES NOT ASSUME ANY RESPONSIBILITY FOR MY USE OR MISUSE OF PATIENT INFORMATION OR OTHER INFORMATION TRANSMITTED, MONITORED, STORED, UPLOADED OR RECEIVED USING THE SITE OR THE SERVICES.

I have read the information above regarding the secured uploading of patient information to the web site for the dental practice, and grant the dental practice permission to securely upload my patient information to the web site.

_____ _____

Signature of patient, parent, or guardian Date

_____

Relationship

**Richard W. Featherstone, DDS**
**880 Seven Hills Dr., Suite #130**
**Henderson, NV 89052**
**702-914-4478**

Per: 2009 Nevada Code
TITLE 54 - PROFESSIONS, OCCUPATIONS AND BUSINESSES
Chapter 629 - Healing Arts Generally
GENERAL PROVISIONS
629.051 - Health care records: Retention; disclosure to patients concerning destruction of records; exceptions; regulations.

Richard W. Featherstone, DDS is required to inform patients:

**(1) The health care records of a person who is less than 23 years of age may not be destroyed; and (2) The health care records of a person who has attained the age of 23 years may be destroyed for those records which have been retained for at least 5 years or for any longer period provided by federal law; and (b) Except as otherwise provided in subsection 7 of NRS629.051 and unless a longer period is provided by federal law, the health care records of a patient who is 23 years of age or older may be destroyed after 5 years pursuant to subsection 1 of NRS 629.051. 2. The State Board of Health shall adopt regulations prescribing the contents of the statements required pursuant to this section.**

**Patient Name: _____** **Date: _____**

**Signature: _____** **Relation: _____**

# Richard W. Featherstone, DDS
# 880 Seven Hills Dr. #130
# Henderson, NV 80952

Due to HIPAA standards we are not allowed to discuss your finances, condition, or treatment with anyone. If you are 18 or over please list anyone you would like us to be able to confer with in regards to you as a patient.

We will disclose information for patients under 18 only to the patient's legal guardian(s) unless otherwise listed here.

☐ Please do not discuss my personal information with anyone but me.

☐ Please discuss my personal information with the following people only:

_____

Full Name Relationship Phone Number

_____

Full Name Relationship Phone Number

_____

Full Name Relationship Phone Number

_____

Patient name (print please)

_____ _____

Signature Date

_____

Relations to patient

# Richard W. Featherstone, DDS

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

I, _____, have received a copy of the **Notice of Privacy Practices** of this office.

_____ _____

Signature Date

**Please Note: It is your right to refuse to sign this acknowledgement.**

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*Office Use Only*

We tried to obtain written acknowledgement by the individual noted above of receipt of our **Notice of Privacy Practices**, but it could not be obtained because:

☐ An emergency prevented us from obtaining acknowledgement.

☐ A communication barrier prevented us from obtaining acknowledgement.

☐ The individual was unwilling to sign.

☐ Other:

_____

_____

_____

_____

# Notice of Privacy Practices

**Richard W. Featherstone, DDS**

**This Notice describes how medical information about you may be used and disclosed and how you can get access to this information.**

We are required by law to maintain the privacy of your health information, to follow the terms of this Notice, and to provide you with this notice of its legal duties and privacy practices with respect to your health information. We will not use or disclose medical information about you without your written authorization, except as described in this Notice. We reserve the right to change our practices and this Notice and to make the new Notice effective for all medical information we maintain. Upon request, we will provide a revised Notice to you.

## How We May Use or Disclose Your Health Information

We protect the privacy of your health information. The law permits us to use or disclose your health information for the following purposes:

- *Treatment, Payment, and Regular Health Care Operations* – Information obtained by us may be used or disclosed to a dental specialist, dental laboratory, or other healthcare provider providing treatment, and to bill your insurance carrier if you have third party coverage, and to record and monitor the service provided to you. Information will also be provided to you upon your request.
- *As and When Required by law* – We may use and disclose your health information to Public Health Officials, Law Enforcement, Health Oversight Activities (for audits, investigations, etc.), Judicial and Administrative, Deceased Person Information, Worker Compensations programs, Food & Drug Administration (FDA for reporting of adverse drug events and quality issues), if there is a serious threat to your health or safety, in times of National Security, if you are in the Military or a Veteran of the armed forces when requested, or if you become an inmate in a correctional facility.
- *Personal Communications* – We may contact you to provide appointment reminders by postcard, voicemail messages, e-mail, letters and other information about treatment alternatives or other health-related benefits and services that may be of interest to you as well as communicate with individuals involved in your care or payment for your care.
- *Disclosure to Our Business Associates* – There are some services provided by us through contracts with business associates. When these services are contracted for, we may disclose health information about you to our business associate so that they can perform the job we have asked them to do and bill you or your third-party payer for services rendered. To protect your health information, we require the business associate to appropriately safeguard the health information.
- *Victims of Abuse, Neglect, or Domestic Violence* – We may disclose your health information to a government authority, such as a social service or protective services agency, if we reasonably believe you are a victim of abuse, neglect, or domestic violence.

***Marketing Communications.*** We must obtain your written authorization prior to using your health information to send you any marketing materials. We may communicate with you about products or services relating to your treatment, care, or alternative treatments, or providers without authorization.

## When We May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, we will not use or disclose your health information without your written authorization. If you do authorize us to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time. If your state law provides additional restrictions upon any of the foregoing uses and disclosures, we must follow your state law.

## You have the following rights with respect to your health information.

- **Access:** You have the right to review or get copies of your health information. To inspect or copy your health information, you must complete a **Request to Inspect/Access Medical Records** and submit the request to the contact information below. We will charge you a reasonable cost-based fee for expenses such as copies, mailing, and staff time. You will be able to review or have a copy of your health information within 30 days of the request. By law, we can have one 30-day extension of time for us to give you access or photocopies if we sent you a written notice of the extension. We may deny your request to inspect and copy in certain limited circumstances. If you are denied access to your health information, you may request that the denial be reviewed.
- **Disclosure of Accounting:** You have a right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, health care operations, where you have provided an authorization and certain other activities, for the past 6 years, but not for disclosure made prior to April 14, 2003. To request an accounting, you must complete a **Request for Accounting of Disclosures** and submit the request to the contact information below. We will usually respond to your request within 60 days of receiving it, but by law, we can have one 30-day extension of time if we notify you of the extension in writing. 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.
- **Restrictions:** You have the right to request that we place additional restrictions on our use or disclosures of your health information. To make such a request, you must complete a **Restriction of the Use of Patient Information** and submit the request to the contact information below. 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 Communications:** You may request communications of your health information by alternative means or at alternative locations. To request confidential communication of your health information, you must submit a request in writing. Your request must state how or when you would like to be contacted. For example, you may request that we contact you about medical matters only in writing or at a different residence or post office box. We will accommodate all reasonable requests.
- **Amendment:** You have the right to request that we amend your health information that is incorrect or incomplete. To request an amendment, you must complete a **Request for Amendment of Medical Records** and submit the request to the contact information below. If we agree, we will amend the information within 60 days of the request. By law, we can have one 30-day extension of time to consider a request for amendment if we sent you a written notice of the extension. We may deny your request under certain circumstances.

If you would like to exercise one or more of these rights, contact us at the information listed at the end of this Notice.

## Changes to this Notice of Privacy Practices

We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with this Notice. The revised notice will be posted in our office and a paper copy will be available upon request.

## For More Information or to Report a Problem

If you have questions or would like additional information about our privacy practices, please contact us. If you believe your privacy rights have been violated, you may request and file a **COMPLAINT FORM** and submit the form to the contact information below, for which there will be no retaliation. If you prefer, you can discuss your complaint in person or by phone. You may also submit a written complaint to the U.S. Department of Health and Human Services.

**Contact Person / HIPPA Officer: Karen Zitzmann Telephone #: (702) 914-4478 FAX (702)837-7531**
**Mailing Address: 880 Seven Hills Dr. Suite 130 Las Vegas, NV 89052**