Welcome to Advent Dental

Thank you for choosing Advent Dental for your dental needs. We promise to do our best to provide you with the finest care available. If you have any questions please do not hesitate to ask or call us.

Today's Date:_____

PATIENT INFORMATION

Name, Last:_____ First:_____ Middle:_____

DOB:____/____/_____ Gender: ❑ Male ❑ Female Social Security #_____-_____-_____

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed

Home Phone #_____ Work #_____ Cell #_____ Other #_____

E-mail:_____ Is it ok to Text and/or E-mail you? ❑ Yes ❑ No Initials_____

Address:_____ City:_____ State:_____ Zip: _____

Employer: _____ Occupation: _____

Is the patient a student? ❑ Yes ❑ No ❑ Full Time ❑ Part Time

Emergency Contact Person:_____ Phone # _____

Spouse or Parent's Name: _____

Employer:_____ Work #_____

Have you or any member of your family been a patient at this office before? ❑ Yes ❑ No If yes, please give us their name(s):_____

_____ Who may we thank for recommending our office to you?_____

Otherwise, how did you learn about our practice? ❑ Insurance ❑ Internet ❑ Mailer ❑ Yellow Pages ❑ TV-Channel # ____ ❑ Other: _____

ACCOUNT RESPONSIBILITY PARTY

Person responsible for account:_____ Currently a patient in our office(s)? ❑ Yes ❑ No

Social Security #_____-_____-_____ DOB:____/____/_____

Drivers License #_____ State License Issued From _____

Home Phone #_____ Cell #_____ E-Mail Address: _____

Address:_____ City:_____ State:_____ Zip: _____

PRIMARY DENTAL INSURANCE

Insured's Name:_____ DOB:____/____/_____ Relationship to Patient: _____

Social Security #_____-_____-_____ Member ID #:_____ Effective Date: _____

Insurance Carrier_____Phone #_____ Employer:_____

Address:_____ City:_____ State:_____ Zip: _____

Group or Policy #_____ Union/Group Name:_____ Local # _____

SECONDARY DENTAL INSURANCE

Insured's Name:_____ DOB:____/____/_____ Relationship to Patient: _____

Social Security #_____-_____-_____ Member ID #:_____ Effective Date: _____

Insurance Carrier_____Phone #_____ Employer:_____

Address:_____ City:_____ State:_____ Zip: _____

Group or Policy #_____ Union/Group Name:_____ Local # _____

DENTAL HISTORY

What is the primary reason for your visit today?_____

Are you aware of any dental problems? If so, please explain: _____

Please share the following dates: Your last Complete... Exam:_____ X-rays:_____ Dental Cleaning:_____

Was there any dental treatment your last dentist recommended for you? If so, please describe:_____

_____

If your dental treatment was NOT completed, what prevented you from receiving it? ❑ Time ❑ Cost ❑ Fear ❑ Other _____

Why did you leave your last dentist? _____

Previous dentist name:_____ City:_____ State: _____ Phone Number:_____

Please check any of the following problems that apply to you:

❑ Sensitivity (hot, cold, sweets) ❑ Bleeding, swollen or irritated gums ❑ Tooth Pain when Chewing
❑ Loose, tipped or shifting teeth ❑ Teeth or Fillings Breaking ❑ Dry Mouth
❑ Jaw Joint Pain ❑ Bad Breath or Bad Taste in Your Mouth ❑ Grinding / Clenching Teeth

Please indicate current / past dental treatments:

❑ Treatment for TMJ ❑ Wear a Night-Guard ❑ Braces
❑ Dentures/Partial Dentures, how old _____U/L _____U/L ❑ Dental Implants, when _____
❑ Deep cleanings/periodontal treatment, when_____ ❑ Teeth Extracted (adult teeth), when_____

If you could whiten your teeth for a cost you could afford, would you do it? ❑ Yes ❑ No

If you could change anything about your smile it would be:

❑ Make them brighter ❑ Make them straighter ❑ Close Spaces
❑ Repair chipped teeth ❑ Replace missing teeth ❑ Replace metal fillings with tooth colored fillings
❑ Alternative to a denture ❑ Get a smile makeover ❑ Replace old crowns that don't match

On a scale of 1-10, with 10 being the highest

How important is your dental health to you? 1 2 3 4 5 6 7 8 9 10

How would you rate your current dental health? 1 2 3 4 5 6 7 8 9 10

MEDICAL HISTORY - please check any of the following that APPLIES TO THE PATIENT:

❑ Aids/HIV +	❑ Anemia	❑ Arthritis	❑ Artificial joints	❑ Artificial heart valve
❑ Seasonal Allergies	❑ Asthma	❑ Blood disease	❑ Bruise easily	❑ Cancer
❑ Chemotherapy	❑ Diabetes	❑ Dizziness	❑ Drug addiction	❑ Emphysema
❑ Excessive bleeding	❑ Fainting	❑ Glaucoma	❑ Heart Conditions	❑ Heart murmur
❑ Hepatitis A / B / C	❑ High blood pressure	❑ Low Blood pressure	❑ Jaundice	❑ Kidney Disease
❑ Mitral valve prolapse	❑ Anxiety / Depression	❑ Pacemaker	❑ Osteoporosis/penia	❑ Radiation
❑ Respiratory illness	❑ Rheumatic fever	❑ Rheumatism	❑ Seizures	❑ Stomach problems
❑ Stroke	❑ Thyroid disease	❑ Currently Pregnant?	❑ Liver Disease	❑ Latex allergy
❑ Allergies to antibiotics	❑ Tuberculosis	❑ Phen-Fen (diet pills)	❑ Other medical condition_____	

Do you smoke or use chewing tobacco? o Yes o No How much?_____ How long? _____
Do you use any recreational drugs? o Yes o No Which drugs? _____
What medical conditions are you currently being treated for? _____
Physicians Name: _____ Phone #_____ Fax #_____
Please list any medications you are currently taking? _____
Please list any medications you are allergic to or have bad reactions to:_____

To the best of my knowledge, I have answered every question completely and accurately. It is my responsibility to inform Advent Dental of any changes in my health and or medications.

Patient/Guardian signature:_____ **Print Name**_____ **Date**_____

- FOR OFFICE USE ONLY -

Dr. Name: _____ **Dr's Signature**_____ **Date:**_____
Dr. Notes: _____
_____
Vitals: BP _____ Pulse_____

Advent Dental

6835 W. Tropicana Ave, Ste. 110
Las Vegas, NV 89103

Payment Policy:

I understand that I am financially responsible for charges not paid by my insurance. I understand that Advent Dental will file my Primary dental insurance; however in the case that I have secondary dental insurance, I understand that I must pay the balance not covered by my Primary Insurance.

As a courtesy, Advent Dental will provide the appropriate paperwork so that I can file for my secondary insurance reimbursement.
I understand that reasonable billing charges may be applied in order to collect any and all unpaid charges. This includes any additional collection costs or fees if necessary.

Cancellation Policy:

24 hours notice is required to cancel or reschedule an appointment.

By scheduling and not keeping an appointment, you are preventing other patients from being seen by the Dentist.

I understand that ultimately I am responsible for keeping track of my appointments. If I am unable to keep the appointment I must give 24 hours notice otherwise I will be charged $25.00, or if I am more than 30 minutes late, without calling I may be charged.
I understand that this practice reserves the right to dismiss patients that fail appointments without 24 hours notice.

_____ _____

Responsible Party Signature Date

Advent Dental

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INSURANCE BILLING INFORMATION

As a courtesy to our patients, we can verify and file your insurance claims. We cannot, however, guarantee payment. We suggest that you read your policy manual pertaining to your dental coverage. Many insurance companies have stipulations, such as usual and customary fees, limitations and procedure, limits to the amount paid per procedure, deductibles, co-payments, etc. This information will be listed in your policy manual. You are responsible for all amounts covered or not covered by your insurance. We have an agreement with you and not your insurance company for payment. Please be aware of this and plan to make payments as services are rendered. In the event of denial from your insurance company, this account will become your responsibility.

Patient Signature or Responsible Party Date

General Consent for Dentistry

1. **Work To Be Done**
   I understand that I am having the following work done today at my first appointment: Exam [ ], X-Rays [ ], Prophy [ ], Other _____
   Initials_____

2. **Drugs and Medication**
   I understand that antibiotics, analgesics and other medication can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock.
   Initials_____

3. **Changes in treatment plan**
   I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination. For example: Root canal therapy following routine restorative procedures. I give my permission to the dentist to make any /all changes and additions as necessary. This will be discussed with me at the time of treatment.
   Initials_____

I understand that dentistry is not an exact science and that therefore, reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment, which I have requested and authorized. I understand that regardless of any dental insurance coverage I may have, I am responsible for payment of dental fees, I agree to pay any attorney fees, collections fees, or court costs that may be incurred to satisfy this obligation.

Patient or Account Guarantors" Signature: _____

Date: _____