PATIENT INFORMATION FORM

DATE____/____/____

FIRST NAME_____
LAST NAME_____

Best # for contact; please check one

Mobil Phone_____ [___]
Home Phone_____ [___]
Work Phone_____ [___]
Email Address_____

Home Address_____ Unit/Apt_____
City_____State_____Zip_____

Date of Birth_____/_____/_____
Social Security Number_____/_____/_____
Driver License Number _____ State_____

Marital Status (PLEASE CIRCLE ONE) Single Married Separated Divorced Widowed

Employer_____
Position_____
Business Address _____
City_____ State_____ Zip_____

WE ARE PROVIDERS FOR MOST INSURANCE COMPANIES. IF YOU HAVE A QUESTION REGARDING YOUR INSURANCE OR YOUR FINANCIAL RESPONSIBILITIES, DO NOT HESITATE TO INQUIRE WITH OUR FRONT DESK STAFF PRIOR TO YOUR APPOINTMENT.

RESPONSIBLE PARTY INFORMATION

(IF PATIENT IS A RESPONSIBLE PARTY FOR THIS ACCOUNT, YOU CAN SKIP THIS SECTION)

Name_____
Home Address_____ Unit/Apt_____
City_____State_____Zip_____
Date of Birth_____/_____/_____
Social Security Number_____/_____/_____
Driver License Number _____ State_____
Employer_____
Position_____
Business Address _____
City_____ State_____ Zip_____

WHOM MAY WE THANK FOR REFERRING YOU

INTERNET [ ] INSURANCE CO. [ ] DROVE BY [ ] MAIL [ ]

EXISTING PATIENT [ ] (Please provide the name) _____

FOR YOUR CONVENIENCE, WE OFFER THE FOLLOWING METHODS OF PAYMENT:
ALL MAJOR CREDIT CARDS: VISA, MASTER CARD, DISCOVERY, AMERICAN EXPRESS
DEBIT/ ATM CARDS
CARE CREDIT
CASH
CASHIERS CHECKS
MONEY ORDERS
SORRY WE DO NOT ACCEPT PERSONAL OR BUSINESS CHECKS
PAYMENT IS EXPECTED IN FULL AT EACH APPOINTMENT.

INSURANCE INFORMATION

INSURANCE COMPANY_____

Group# _____Policy #_____

Insurance ID (if applicable)_____

Insurance Phone #_____

Effective Date of Coverage_____

Name of the Insured_____

Name of the Employer_____

SECONDARY INSURANCE(If secondary insurance is available, please provide information below.

Failure to disclose insurance information constitutes an insurance fraud, a felony in the state of Nevada; NVCC1349.33)

INSURANCE COMPANY_____

Group# _____Policy #_____

Insurance ID (if applicable)_____

Insurance Phone #_____

Effective Date of Coverage_____

Name of the Insured_____

Name of the Employer_____

EMERGENCY CONTACT NAME_____Phone_____

Relationship_____

PLEASE LIST THE NAMES WHOM YOU ALLOW US TO SHARE YOUR TREATMENT AND ACCOUNT INFO _____ _____

PATIENT MEDICAL HISTORY

Are you under medical treatment now? YES NO

If YES, please list what king_____

_____

Have you ever been hospitalized for any surgery or serious illness? YES NO

If YES, please explain_____

_____

WOMEN ONLY:

Are you pregnant? YES NO

Is there any chance you might be pregnant? YES NO

Are you nursing? YES NO

Are you on any contraceptives? YES NO

ARE YOU ALLERGIC TO OR HAVE YOU HAD ANY REACTION TO THE FOLLOWING?

Antibiotic YES NO If YES, please list_____

_____

Local Anesthetic YES NO If YES, please explain_____

Sulfa YES NO

Barbiturates YES NO

Sedatives YES NO

Iodine YES NO

Shellfish YES NO

Aspirin YES NO

Codeine YES NO

Metals YES NO

Latex YES NO

Hay Fever YES NO

Other YES NO. If YES, please list _____

_____

Do you drink alcoholic beverages? YES NO

If YES, how often? # of drinks _____/ day/ week/ month

Do you use Controlled Substances? YES NO

If YES, Please list what kind?_____. Frequency_____

_____. Frequency_____

Do you use opioids (pain medications) on the regular basis? YES NO

If YES, Please list what kind?_____. Frequency_____

_____. Frequency_____

Do you take Osteoporosis Medication? YES NO

If YES, Please list what kind?_____. Frequency_____ For how Long_____

DO YOU HAVE/ HAD ANY OF THE FOLLOWING?

High Blood Pressure YES NO Past Present Controlled Not controlled
Low Blood Pressure YES NO Past Present Controlled Not controlled
Heart Attack YES NO When?_____
Stroke YES NO When?_____
Chest Pains YES NO
Night Sweats YES NO Past Present
Cardiac Pacemaker YES NO Date of Placement _____
Defibrillator YES NO Date of Placement _____
Heart Murmur YES NO Past Present
Mitral Valve Prolapse YES NO
Angina YES NO
Rheumatic Fever YES NO
Fainting/Seizures YES NO Past Present
Epilepsy/Convulsions YES NO Past Present
Cancer YES NO Past Present When diagnosed? _____
Radiation Therapy YES NO Past Present When diagnosed? _____ How Long?_____
Chemotherapy YES NO Past Present When diagnosed? _____ How Long?_____
Diabetes YES NO Type_____ Controlled Not controlled
Kidney Disease YES NO
Thyroid Problem YES NO Controlled Not controlled
Asthma YES NO If YES, do you use an inhaler? YES NO How often?_____
Emphysema YES NO
Any autoimmune conditions YES NO If YES, what kind?_____
Hepatitis/Jaundice YES NO Past Present
Ulcer/Acid Reflux YES NO Past Present
Anemia YES NO Past Present
Easily Wounded YES NO Past Present
Arthritis YES NO
Joint Replacement YES NO What joint?_____
Date of placement?_____
What joint?_____
Date of placement?_____
Breast Implant YES NO Date of Placement?_____
Sexually Transmitted Disease YES NO What Kind?_____
Liver Disease YES NO
Other _____
Were you told to take antibiotics prior to dental appointments? YES NO
Were you advised by your physician of any precautions for dental appointment? YES NO
If YES, please explain_____

MEDICATIOS

Please list all prescriptions and non-prescription medications that you are taking (includion vitamins and supplements?

NAME	DOSAGE	FREQUENCY

AUTHORIZATION AND RELEASE

I _____, certify that i have read, understood asked questions 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. Initial_____

I_____,authorize dentist and dental office staff to release any information including diagnosis and records of any treatment or examination rendered to me or my child during the period of such dental care to the third party payers and/or health practitioners. Initial_____

I_____, authorize and request my insurance company to pay insurance benefits directly to the dentist or dental group otherwise payable to me Initial_____

I understand that my dental insurance carrier may pay less than the actual bill of services. I_____, agree to be responsible for the payment of all services rendered. Initial_____

I_____, understand and agree with 18% interest charge recurring on each 30-day after the initial bill. Account becomes delinquent in 180 days after the initial bill. At that time, bill will be forwarded to the small claims court. That will carry $300 charge in addition to the pre-court amount of bill and court filing fees. Initial_____

Name of patient/ guardian _____

Signature of patient/ guardian_____

Date _____/_____/_____

You May Refuse To Sign This Acknowledgement

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

_____

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:

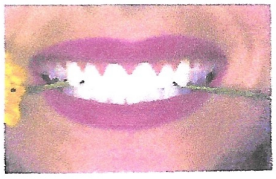
_____ Individual refused to sign

_____ Communication barriers prohibited obtaining the acknowledgement

_____An emergency situation prevented us from obtaining acknowledgement

_____ Other

_____



WIGWAM DENTAL CARE
2649 WIGWAM PKWY #106
LAS VEGAS, NV 89074
(702)617 3333

APPOINTMENT CANCELLATION POLICY

We understand that unplanned issues can come up and you may need to cancel or reschedule an appointment. If that happens, we respectfully ask for the scheduled appointments to be canceled or rescheduled with 24 hour notice. Our doctors and hygienists want to be available for your needs and the needs of all our patients. When a patient does not show up for a scheduled appointment, another patient loses an opportunity to be seen. Although we have always had a cancellation policy,

circumstances have caused us to enforce our policy.

Effective immediately there will be a fee of $35.00 for cancellation/reschedule/no-show appointments at any time that 24 hour notice is not given. Thank you for being a valued patient and for your understanding and cooperation as we institute this policy. This policy will enable us to open otherwise unused appointments to better serve the needs of all patients.Thank you for your kind understanding.

Signature:_____

DATE:_____

WIGWAM DENTAL CARE
2649 Wigwam Pkwy. #106
Henderson, NV 89074
PH: (702)617-3333
FAX: (702) 617-0332

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW THE HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT 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 your 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. This Notice takes effect 9/23/13, and will remain in effect until we replace it.

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 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 additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

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

Treatment: We may use and disclose your health information to a physician or other healthcare providers 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 or 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 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 and 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 to your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose your 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 judgement disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgement and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, dental supplies, x-rays, or other similar forms of your health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: When required to do so by law. We may disclose your health information to the appropriate authorities.

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 a 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 the health information of Armed Forces personnel under certain circumstances. We may disclose to authorize federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correction institutions or law enforcement officials having lawful custody of protected health information of inmates or patients under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of 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. (You must make a request in writing to obtain access to your health information. You may also request access by sending us a letter to the address at the end of this notice. If you request copies we will NOT charge you.

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.

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 can abide by our agreement (except in an emergency).

Alternate Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations (you just make your request 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. (Your 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 receive this Notice on our website or by electronic mail, you are entitled to receive this notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use of disclosure of your health information or to have us communicate with you by alternative means or at alternative locations. You may complain to us using the contact information listed at the end of this notice. You also may submit a written complaint to the U.S. Department Of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department Of Human Services upon request.

We support your right to 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.

Contact Officer: Sabina Telephone: 702-304-1234 Fax: 702-304-9499

Email: lakemeaddental@gmail.com

Address: 7481 W. Lake Mead Blvd #100, Las Vegas, NV 89128