Salar And Delisle LLC
5059 S McCarran Blvd, Reno, NV 89502
PH: 775-909-4356 FX: 775-909-4354
Email: Info@toothFairyPediatricDental.com

ADULT/CHILD HEALTH HISTORY – HEALTH HX

Patient Information (Confidential) Today's Date: _____

Name: _____ Date of Birth: _____ Age: _____ Gender:____

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

Home Phone: _____ SSN:_____ Email: _____

Cell : _____ Accept text: Y N Mobil Carrier _____

RESPONSIBLE PARTY

Responsible party (circle one) Self / Parent / Guardian / Group Home & Care Taker:

_____

Name of Person Responsible for the Account: _____

Home Phone: _____ Alt # _____ SSN:_____

MEDICAL HISTORY

Please describe the patient's current health (**Circle**): EXCELLENT GOOD POOR

Height: _____ Weight: _____

Has the patient ever had any of the following medical problems?

Y N Diabetes
Y N Cancer
Y N Tuberculosis
Y N Cerebral Palsy
Y N Currently Pregnant
Y N Latex Allergy
Y N Anxiety
Y N Other:

Y N Family Hx of Problems w/ Anesthesia
Y N Asthma/Lung Problems/COPD/Sleep Apnea
Y N Heart Defects/Heart Murmurs/Surgery
Y N Bleeding Problems
Y N Rheumatic / Scarlet Fever
Y N Autism / Down syndrome
Y N Allergies to any drugs

Y N Joint Replacements
Y N Any Hospital Stays
Y N Any Operations
Y N Kidney Disease/Failure/Problems
Y N Endocrine Disease
Y N Seizures / Epilepsy
Y N Developmentally Delayed
Y N bisphosphonates Use

Please discuss any medical problems the patient has/had:

_____

_____

Please list all medications the patient is currently taking:

MEDICATION	DOSE	DIRECTIONS

Is the patient currently under the care of a physician? Y N Date of Last Visit: _____

Physician: _____ Office Number: _____ Fax Number: _____

The information on this questionnaire is accurate to the best of my knowledge. I understand that the information will be held in the strictest of confidence and it is my responsibility to inform the doctor of any changes in my child's medical status at the earliest possible time.

Signature of Patient/Parent/Legal Guardian: _____ Date: _____

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PATIENT INTAKE & INSURANCE INFORMATION – INS INFO

Patient Information

Name: _____ Date of Birth: _____ Age: _____

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

Home Phone: _____ Alt #:_____SSN:_____

FOR PATIENT UNDER AGE OF 18 (MINORS)

PARENT/GUARDIAN #1

Name: _____

Date of Birth: _____

Address: _____

City, State, Zip: _____

Home Phone: _____

Cell Phone: _____

Social Security Number: _____-____-_____

Employer: _____

Occupation: _____

Work Phone: _____ Ext: _____

PARENT/GURADIAN #2

Name: _____

Date of Birth: _____

Address: _____

City, State, Zip: _____

Home Phone: _____

Cell Phone: _____

Social Security Number: _____-____-_____

Employer: _____

Occupation: _____

Work Phone: _____ Ext: _____

DENTAL INSURANCE INFORMATION

PRIMARY DENTAL COVERAGE

Insurance Company:_____

Phone Number: _____

Group/Policy Number: _____

Subscriber Name: _____

Subscriber ID: _____

Subscriber Date of Birth: ____/_____/_____

Subscriber SSN: _____-____-_____

Insurance Company:_____

Phone Number: _____

Group/Policy Number: _____

Subscriber Name: _____

Subscriber ID: _____

Subscriber Date of Birth: ____/_____/_____

Subscriber SSN: _____-____-_____

**** Please notify the front desk staff if additional dental coverage is available**

REFERRAL INFORMATION

☐ Website ☐ Insurance ☐ Digital Ad ☐ Print Ad ☐ Health Provider Referral ☐ Event/Fair

☐ School ☐ Another Tooth Fairy Location ☐ Other _____

I have reviewed the above information and acknowledge my answers are true and accurate. I also acknowledge full responsibility for my account regardless of any insurance involvement.

Signature of Patient/Parent/Legal Guardian: _____ **Date:** _____

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FINANCIAL POLICY

To avoid any questions regarding our financial policy, please read the following statements carefully:
****PAYMENT IS DUE PRIOR TO SERVICES RENDERED and is expected before treatment *regardless* of any insurance involvement. ****
*We accept Cash, Debit Cards, MasterCard, Visa, American Express and Care Credit all with valid ID. No checks accepted.
*Financing is available through Care Credit for treatment. Patients may enroll at CareCredit.com.
*Any account over 90 days is considered delinquent and could be subject to third party collection. Any fees associated with third party collection are the responsibility of the parent/guardian.

HIPAA

In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), personal identifiable information will be used for, but not limited to, the following: treatment; to obtain pre-treatment authorization or payment from dental insurance; to obtain records from previous dental office; referral to a specialist; referral to a surgery center and associated anesthesiologist; electronic claims submissions; fax transmissions; sign in sheets; appointment reminders or recall cards; or for third party collection on delinquent accounts. A full disclosure of HIPAA statement is available at the front desk and is posted in the office. We use business associate agreements with any company that may come in contact with your health information. This business associate agreement is an agreement on their part to keep your information private and protected.

FOR PATIENTS WITH DENTAL INSURANCE: Due to the HIPAA laws, we are provided *general* information only about your dental policy. Your child's previous dental history is not disclosed when verifying eligibility. *It is the parent/caregiver or adult patient's responsibility* to notify the office of previous dental procedures such as bitewing films, panoramic films and sealants. We accept no responsibility if your insurance denies payment**.** Our office assumes no responsibility for ANY insurance information received, including but not limited to the allowable benefits; limitations; restrictions; exclusions; termination date; or 'cobra' status of a policy. Dental insurance is a contract between the subscriber and the insurance company, not the dental office. It is the responsibility of the subscriber/parent to understand their dental policy and limitations, restrictions or exclusions cobra status or termination date specific to that policy. This information is available from the Human Resource department, directly from the dental carrier or in the policy handouts provided by the employer

IF YOUR INSURANCE IS NOT LISTED ABOVE, we may be out-of-network with your dental carrier. Contact your dental carrier to verify our 'network' status. If you are out of network, we may still be able to treat the patient. Out of network benefits are assigned to the patient not the provider therefore the entire cost of dental treatment will have to be paid up front, any dental benefits will be sent to the subscriber by the insurance company. All co-payments for out-of-network plans are *estimated* and based on a 'reasonable and customary' fee schedule utilized nationally by dental carriers for "out of network" providers. Estimated co-payments are due at the time of visit. If your (or your child) requires extensive dental treatment, our office will submit a pre-treatment estimate prior to initiating treatment. ***You will be responsible for ANY balance not covered by your dental carrier. Any disputes are handled by the subscriber directly with their insurance.***

PRE-TREATMENT ESTIMATES are never a guarantee of benefit or payment. **Actual benefit is not determined until your insurance receives a treatment claim for final processing**. Most insurance companies have specific guidelines regarding payment for procedures. Dental benefits are based on your yearly maximum allowance, deductible, and any limitations, restrictions or exclusions specific to your policy, and the fee schedule established by your dental carrier. Also, many insurance companies have a 'maximum allowable' per procedure which may be less than the fees submitted by our office. **The patient, parent or guardian is responsible for ANY remaining balance unless otherwise determined by a participating provider contract as stated above**. If you have dual coverage, the secondary carrier will base payment on the 'coordination of benefits' clause. Dual insurance does not guarantee payment in full for treatment. Read the information offered by your insurance to understand coordination of benefits clause.

Insurance claims or pre-treatment estimates are submitted as a courtesy to our patients. The filing of your dental claim in no way reduces your personal or financial responsibility or obligation to the office. We will resubmit claims one time if an insurance company does not respond with an authorization or payment within 60 days. Regardless of a patient's affiliation with a specific dental insurance or the type of dental coverage, the patient and/or subscriber are ultimately responsible for **ANY** unpaid balance.

ANESTHESIA PATIENTS paying with credit card may be charged half the cost of the *estimated* treatment cost prior to treatment, with the remaining balance charged prior to or after services are rendered. Please note that the actual anesthesia cost is based on treatment time which may run shorter or longer than anticipated. Cancelled anesthesia appointments may be subject to half the cost of the estimated treatment, which would be applied as a credit to the patient upon a completed treatment.

I have read, understand and accept the financial policy contract. I understand and fully accept the financial responsibility for myself/my child/children's account. I understand and fully accept that I am responsible for ANY balance on the account regardless of my involvement with any dental insurance. If I am insured, my signature allows for assignment of benefits directly to Salar And Delisle LLC. *This agreement covers but is not limited to consults, exams and treatments performed from the initial date up to 1 (one) year.*

Patient/Parent/Guardian Signature _____ **Date** _____

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PATIENT PRIVACY & DISCLOSURE AUTHORIZATION - HIPPA

OUR PRIVACY PLEDGE

We respect your privacy. Other than the necessary uses and disclosures we describe, we will not sell your health information or provide any of your health information to any outside marketing company.

USES & DISCLOSURES

Below you will find examples of how we may have to use or disclose your health care information:

a. Your doctor or a staff member may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for diagnosis, assessment or treatment of your health condition.
b. It may be necessary for our insurance and/or billing staff to disclose your examination and treatment records and your billing records to another party, such as an insurance carrier, your employer, a family member, other relative or close personal friend, who is involved in your care or to facilitate the payment related to your care.
c. It may be necessary to use your health information, examination and treatment records / billing records for quality control purposes or for other administrative purposes to efficiently and effectively run our practice.
d. It may be necessary to use your information (ex. Name, address, phone number, and your clinical records) to contact you to provide appointment reminders, information about treatment alternatives, or other health related information that may be of interested to you. 164520(b)(1)(iii)(A). If you are not at home to receive an appointment reminder, a message will be left on your answering machine. *Note, as our patient you do possess the 'right to refuse' our office to contact you regarding the above-mentioned circumstances. However, if you do not give us authorization, it could affect the methods we use to obtain reimbursement for your care.

PERMITTED USES AND DISCLOSURES WITHOUT YOUR CONSENT OR AUTHORIZATION

Under federal law, we are permitted or required to use or disclose your health information without your consent or authorization in these following circumstances:

1. If we are providing services to you based on the orders of another health care provider.
2. If we provide health care services to you in an emergency or disaster relief situation.
3. If we are required by law to treat you and we are unable to obtain your consent after attempting to do so.
4. If we provide health care services to you as a result of a Worker's Compensation injury.
5. If you are/were a member of the armed forces, we are required by military command authorities to release your health information.
6. If we provide health care services to you as an inmate.
7. If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.

Other than the circumstances above, any other use or disclosure of your health information will only be made with your written consent.

Your right to revoke your authorization

You may revoke your privacy release authorization from us at any time. However, your revocation must be in writing. You can call for information about revoking your authorization during normal business hours, or send your request to the address above. There are two circumstances under which we will not be able to honor your revocation request.

1. If we have already released your health information before we have received your request to revoke authorization. 164.508(b)(5)(i).
2. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims. If you wish to revoke your authorization, a written statement must be received at Salar And Delisle PLLC.

Your right to limit use or disclosures

If there are health care providers, hospitals, employers, insurers, or other individuals or organizations to whom you do not want us to disclose your health information, please let us know in writing what individuals or organizations to whom you do not want us to disclose your health information. We are not required to agree to your restrictions. However if we agree with your restrictions, the restriction is binding on us. If we do not agree to your restrictions, you may drop your request or you are free to seek care from another health care provider.

We normally provide information about your health to you in person at the time you receive services from us. We may also mail you information regarding your health or about the status of your account. We will do our best to accommodate any reasonable request if you would like to receive information in a different form. To help us respond to your needs, please make any request in writing.

Your right to inspect and copy your health information

You have the right to inspect and copy your health information for seven years from the date the record was created or as long as the information remains in our files. We require your request to inspect and/or copy your health information be in writing.

Your right to amend your health information

You have the right to request that we amend your health information for seven years from the date the record was created or as long as the information remains in our files. We require your request to amend your records to be in writing and for you to give us a reason to support the change you are requesting us to make.

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Your right to receive an accounting of the disclosures we have made of your records.
(PATIENT PRIVACY CONT'D) - HIPPA

You have a right to request that we give you an accounting if the disclosures we have made of your health information for the last six years before the date of your request. This accounting will include all disclosures except:

- Those disclosures required for your treatment, to obtain payment for your services or to run our practice.
- Those disclosures made to you.
- Those disclosures necessary to maintain a directory of the individuals in our facility or to individuals involved in your care.
- Those disclosures made for national security or intelligence purposes.
- Those disclosures made to correctional officers or law enforcement officers.
- Those disclosures that were made prior to the effective date of the HIPPA privacy law.

Our duties
We are required by law to maintain the privacy of your health information. We are also required to provide you with this notice of our legal duties and our privacy practices with respect to your health information.

We must abide by the terms of this notice while it is in effect. However, we reserve the right to change the terms of our privacy notices. If we make a change in our privacy terms the change will apply for all of our health information in our files.

Re-disclosure
Information that we use or disclose may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

For more information or to report a problem
If you have any questions and would like additional information, you may contact our practice in writing. If you believe your privacy rights have been violated, you can either file a complaint with Sedation Dental Center of Las Vegas, or with the office of Civil Rights, U.S. Department of Health and Human Services (OCR). There will be no retaliation for filing a complaint with either our practice or the OCR. The address for the OCR regional office for Las Vegas is as follows:

PLEASE CHOOSE AND SIGN ONE
****Please initial the box that applies ****

[___] ***I AUTHORIZE*** Salar And Delisle LLC *to use or disclose my health information in the manner described above.*
Authorization to release records: *I voluntarily authorize the release of any information pertinent to my case to any insurance company, adjuster, attorney or care facility involved in my health and well-being. I am also acknowledging that I understand that I may receive a paper copy with this authorization at my request. This authorization will expire seven years after the date in which you last received services from us, unless we receive written notice to term this authorization sooner.*
Patient Name: _____

Signature of Patient/Parent/Legal Guardian: _____ **Date:** _____

[___] ***I DO NOT AUTHORIZE*** Salar And Delisle LLC *to use or disclose my health information in the manner described above.*

Signature of Patient/Parent/Legal Guardian: _____ **Date:** _____

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ADULT DENTAL CONSENT

Please initial the boxes

[____] I attest that I am the legal permanent guardian of the patient. Temporary guardian, relative, or foster parent cannot give consent to dental treatment or anesthesia.

[____] 1. **X-RAYS, PHOTOGRAPHS, PREVENTATIVE**
X rays and photographs may be necessary to document and diagnose dental decay and oral hygiene. I understand that photos and x rays are private clinical records and will not be shared with anyone but the guardian. I consent to preventative care including prophylaxis, fluoride, sealants, and Full Mouth debridement if necessary for diagnosis.

[____] 2. **DRUGS & MEDICATIONS**
I Consent to the use of medications necessary to the treatment of dental treatment. I have had the chance to ask the dentist questions regarding the medication used. I understand there is a risk of allergic reaction to all medications. I consent to the use of Local Anesthesia for my dental treatment. I understand that local anesthesia may contain epinephrine, and have advised my dentist if I have any cardiac disease, medications may include, local anesthesia, botox, sedatives, analgesics, antibiotics, anti-inflammatory.

[____] 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, the most common being root canal therapy following routine restorative procedures. I give my permission to the Dentist to make any/all changes and additions as necessary. If I am choosing sedation, and the treatment plan changes during the sedation

☐ I DO wish to continue treatment at the dentist's discretion

☐ I do NOT wish to continue treatment, The dentist should end the procedure and wake me up to discuss further options.

[____] 4. **REMOVAL OF TEETH**
Alternatives to removal have been explained to me (root canal therapy, crowns, and periodontal surgery, etc.) and I authorize the Dentist to remove the following teeth and any others necessary for reason in Paragraph #3. I understand removing teeth does not always remove all the infection, if present, and it may be necessary to have further treatment. I understand the risks involved in having teeth removed, some of which are pain, swelling, spread of infection, dry socket, loss of feeling in my teeth, lips, tongue, and surrounding tissue (paresthesia) that can last for an indefinite period of time (days or months) or fractured jaw. I understand I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment, the cost of which is my responsibility. I understand other options may include no treatment, obtaining 2nd opinion or seeing a specialist.

[____] 5. **CROWNS and BRIDGES**
I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth.

I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I understand I need a crown/bridge to cover the entire tooth due to decay, fracture or root canal treatment. My crown, bridge may be all ceramic, or may contain gold and base metal. I have discussed the options with my dentists. I realize the final opportunity to make changes in my new crown, bridge, or cap (including shape, fit, size and color) will be before cementation. If the temporary crown is dislodged, I understand it is my responsibility to notify the office ASAP, to have the temporary crown re-cemented. Failure to notify the dentist of a temporary crown falling off, may result in the permanent crown not fitting correctly. Crowns and bridges may need adjustment to get occlusion correct.

[____] 6. **DENTURES: COMPLETE OR PARTIAL**
I realize that full or partial dentures are artificial, constructed of plastic, metal, and/or porcelain. The problems of wearing these appliances have been explained to me, including looseness, soreness, and possible breakage. I realize the final opportunity to make changes in my new dentures (including shape, fit, size, placement and color) will be in the "teeth in wax" try-in visit. I understand that most dentures require relining approximately three to twelve months after final placement. The cost for this procedure is not included in the initial denture fee.

[____] 7. **ENDODONTIC (ROOT CANAL)**
I realize there is no guarantee that root canal treatment will save my tooth, and that complications can occur from the treatment, and that occasionally metal files may break in the root canal, which does not necessarily affect the success of the treatment. . I understand I need a root canal because of decay extending into the pulp, pulpitis, or necrosis of the pulp. I understand that occasionally additional surgical procedures may also be necessary following root canal treatment (apicoectomy). I understand I have the option of seeing a specialist. .

[____] 8. **PERIODONTAL Therapy (SRP's)**
I understand that I have been diagnosed with periodontal disease, mild, moderate, or severe. I understand that periodontal disease is not curable, but therapy to prevent further bone loss and attachment loss has been recommended to me by my dentist. I have been educated that good hygiene is the best way to prevent the progression of periodontal disease, and scaling and root planning, followed by periodontal maintenance is the treatment I am receiving.

[____] 9. **FILLINGS**
I understand that tooth decay requires a filling to replace missing tooth structure. I understand that I may be receiving a silver amalgam or a composite filling, and have discussed the options with my dentist. I understand that a more expensive filling than initially diagnosed may be required due to additional decay. I understand that significant sensitivity is a common after effect of a newly placed filling.

[____]All my questions have been answered and I have had time to discuss with the dentists the proposed treatment.

I understand that dentistry is not an exact science and therefore, reputable practitioners may have different treatment plans. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorized. I have had the opportunity to read this form and ask any questions. This consent covers consults, exams and treatment performed from initial date up to 1 year. I understand the proposed treatment, adverse outcomes, and alternatives viable and have the chance to adequately discuss treatment and alternatives with the dentist.

Patient/Parent Name:_____ **Date:** _____

Signature of patient or parent/legal _____ **Date:**_____

Reviewed by: DDS _____ ***Date:*** _____

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PEDIATRIC DENTAL CONSENT

Please initial the boxes

[____] I attest that I am the legal permanent guardian of the patient. Temporary guardian, relative, or foster parent cannot give consent to anesthesia.

[____] 1. **X-RAYS, PHOTOGRAPHS, PREVENTATIVE**

X rays and photographs may be necessary to document and diagnose dental decay and oral hygiene. I understand that photos and x rays are private clinical records and will not be shared with anyone but the guardian. I consent to preventative care including prophylaxis, fluoride, sealants, and Full Mouth debridement if necessary for diagnosis.

[____] 2. **DRUGS & MEDICATIONS**

I Consent to the use of medications necessary to the treatment of dental treatment. I have had the chance to ask the dentist questions regarding the medication used. I understand there is a risk of allergic reaction to all medications. I consent to the use of Local Anesthesia for my dental treatment. I understand that local anesthesia may contain epinephrine, and have advised my dentist if I have any cardiac disease, medications may include, local anesthesia, botox, sedatives, analgesics, antibiotics, anti-inflammatory.

[____] 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, the most common being root canal therapy following routine restorative procedures. I give my permission to the Dentist to make any/all changes and additions as necessary. If I am choosing sedation, and the treatment plan changes during the sedation

☐ I DO wish to continue treatment at the dentist's discretion

☐ I do NOT wish to continue treatment, The dentist should end the procedure and wake me up to discuss further options.

[____] 4. **REMOVAL OF TEETH**

Alternatives to removal have been explained to me (root canal therapy, crowns, and periodontal surgery, etc.) and I authorize the Dentist to remove the following teeth and any others necessary for reason in Paragraph #3. I understand removing teeth does not always remove all the infection, if present, and it may be necessary to have further treatment. I understand the risks involved in having teeth removed, some of which are pain, swelling, spread of infection, dry socket, loss of feeling in my teeth, lips, tongue, and surrounding tissue (paresthesia) that can last for an indefinite period of time (days or months) or fractured jaw. I understand I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment, the cost of which is my responsibility. I understand other options may include no treatment, obtaining 2nd opinion or seeing a specialist.

[____] 5. **STAINLESS STEEL CROWNS (SSC)**

I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth.
I understand I need a stainless steel crown to cover the entire tooth due to decay, fracture or pulpotomy. My crown is made out of stainless steel. I have discussed the options with my dentists. If the crown is dislodged, I understand it is my responsibility to notify the office ASAP, to have the crown re-cemented. Failure to notify the dentist of a crown falling off, may result in new office visit to have a new SSC placed. Crowns may need adjustment to get occlusion correct.

[____] 7. **PULPOTOMY (ROOT CANAL)**

I realize there is no guarantee that pulpotomy/pulpectomy treatment will save my tooth, and that complications can occur from the treatment, and that occasionally metal files may break in the root canal, which does not necessarily affect the success of the treatment. I understand I need a pulpotomy/pulpectomy because of decay extending into the pulp, pulpitis, or necrosis of the pulp. I understand I have the option of seeing a specialist.

[____] 8. **PERIODONTAL Therapy (SRP's)**

I understand that I have been diagnosed with periodontal disease, mild, moderate, or severe. I understand that periodontal disease is not curable, but therapy to prevent further bone loss and attachment loss has been recommended to me by my dentist. I have been educated that good hygiene is the best way to prevent the progression of periodontal disease, and scaling and root planning, followed by periodontal maintenance is the treatment I am receiving.

[____] 9. **FILLINGS**

I understand that tooth decay requires a filling to replace missing tooth structure. I understand that I may be receiving a silver amalgam or a composite filling, and have discussed the options with my dentist. I understand that a more expensive filling than initially diagnosed may be required due to additional decay. I understand that significant sensitivity is a common after effect of a newly placed filling.

[____]All my questions have been answered and I have had time to discuss with the dentists the proposed treatment.

I understand that dentistry is not an exact science and therefore, reputable practitioners may have different treatment plans. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorized. I have had the opportunity to read this form and ask any questions. This consent covers consults, exams and treatment performed from initial date up to 1 year. I understand the proposed treatment, adverse outcomes, and alternatives viable and have the chance to adequately discuss treatment and alternatives with the dentist.

Patient/Parent Name:_____ **Date:** _____

Signature of patient or parent/legal guardian: _____ **Date:** _____

Reviewed by: DDS _____ ***Date:*** _____