



Summerlin Center for  
*Aesthetic Dentistry*

(702) 240-0400

### Patient Information

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Last First MI  
 Male  Female  Married  Single  Child  Other \_\_\_\_\_ Birth Date: \_\_\_\_\_  
Social Security #: \_\_\_\_\_ Driver's License # \_\_\_\_\_ State \_\_\_\_\_  
Phone (Home): \_\_\_\_\_ (Work): \_\_\_\_\_ Ext: \_\_\_\_\_ Best time to call: \_\_\_\_\_  
(Cell) \_\_\_\_\_ E-Mail: \_\_\_\_\_  
Address: \_\_\_\_\_  
Street Apartment #  
City State Zip Code

### Referral Information

Whom may we thank for referring you to our practice? \_\_\_\_\_

### Spouse or Responsible Party Information

The following is for:  the patient's spouse  the person responsible for payment  Self-same as above  
Name: \_\_\_\_\_  
 Male  Female  Married  Single  Child  Other \_\_\_\_\_  
Social Security #: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Driver's License # \_\_\_\_\_  
Phone (Home): \_\_\_\_\_ (Work): \_\_\_\_\_  
Address: \_\_\_\_\_  
Street Apartment #  
City State Zip Code

### Employment Information

The following is for:  the patient  the person responsible for payment  Self-same as above  
Employer Name: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Address: \_\_\_\_\_  
Street City State Zip Code

### Insurance Information

Name of Insured: \_\_\_\_\_ Is insured a patient?  Yes  No  
Last First MI  
Insured's Birth Date: \_\_\_\_\_ ID #: \_\_\_\_\_ Group #: \_\_\_\_\_  
Insured's Address: \_\_\_\_\_  
Street City State Zip Code  
Insured's Employer Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Street City State Zip Code  
Patient's relationship to insured:  Self  Spouse  Child  Other \_\_\_\_\_  
Insurance Plan Name and Telephone: \_\_\_\_\_

## Health Information

Previous Dentist: \_\_\_\_\_ Date of Last Dental Visit: \_\_\_\_\_

Reason for this visit: \_\_\_\_\_

### Have you ever had any of the following?

Y	N	Y	N	Y	N			
<input type="checkbox"/>	<input type="checkbox"/>	Allergies:	<input type="checkbox"/>	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Nervous Disorders
		_____						
<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Growths	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric/Psychological Care
<input type="checkbox"/>	<input type="checkbox"/>	Artificial Joints	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	<b>Pregnancy</b> Due Date: _____
<input type="checkbox"/>	<input type="checkbox"/>	Artificial Heart Valve	<input type="checkbox"/>	<input type="checkbox"/>	H.I.V. Positive	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Treatment
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Head Injuries	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory Problems
<input type="checkbox"/>	<input type="checkbox"/>	Blood Disease	<input type="checkbox"/>	<input type="checkbox"/>	Heart (Attack, Disease, Surgery)	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever
<input type="checkbox"/>	<input type="checkbox"/>	Bruise Easily	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatism
<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Venereal Disease	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Problems
<input type="checkbox"/>	<input type="checkbox"/>	Cold Sores/Fever Blisters	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Smoke/Chew Tobacco
<input type="checkbox"/>	<input type="checkbox"/>	Contact Lenses	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Problems
<input type="checkbox"/>	<input type="checkbox"/>	Cortisone Medication	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Stroke
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems
<input type="checkbox"/>	<input type="checkbox"/>	Diet (Special/Restricted)	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis
<input type="checkbox"/>	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	Tumors
			<input type="checkbox"/>	<input type="checkbox"/>	Latex Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	Adverse to Medication or Any Substance Please Specify: _____
<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____
<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Mental Disorders			_____
<input type="checkbox"/>	<input type="checkbox"/>	Excessive Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse			

Have you ever had any complications following dental treatment?  Yes  No

If yes, please explain: \_\_\_\_\_

Have you been admitted to a hospital or needed emergency care during the past two years?  Yes  No

If yes, please explain: \_\_\_\_\_

Are you now under the care of a physician?  Yes  No

If yes, please explain: \_\_\_\_\_

Name and Phone of Physician: \_\_\_\_\_

Do you have any health problems that need further clarification?  Yes  No

If yes, please explain: \_\_\_\_\_

Are you taking any medications? Please list: \_\_\_\_\_

**To the best of my knowledge, all of the preceding answers and information provided are true and correct.  
If I ever have any change in my health, I will inform the doctor at the next appointment without fail.**

Date: \_\_\_\_\_

**Electronic signature of patient, parent or guardian**

## Cosmetic Information

Is there anything about your smile that you do not like? \_\_\_\_\_

Are you interested in knowing the options available for a more beautiful smile? \_\_\_\_\_

Do you like the appearance of your teeth? \_\_\_\_\_

Are all of your teeth in alignment (straight)? \_\_\_\_\_

Do you have any missing teeth? \_\_\_\_\_ Are any chipped? \_\_\_\_\_

Is your bite comfortable when chewing, biting? \_\_\_\_\_

Do you have frequent headaches? \_\_\_\_\_

Do you have any old fillings or dental treatment that you are unhappy with? \_\_\_\_\_

What would you like to change the most about the appearance of your teeth? \_\_\_\_\_

Is there anything else that you would like us to know? \_\_\_\_\_

## Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon payment from the patients for the costs incurred in their care, and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms, including any necessary narratives, x-rays or photographs and the insurance company is asked to reimburse the insured directly. However, this dental office does not render services on the assumption our charges will be paid by an insurance company.

A service charge of 1.75% per month (21% per annum) on the unpaid balance will be charged on all accounts exceeding sixty (60) days, unless previously written financial arrangements are satisfied.

I understand that any fee estimate provided by this office for my dental care can only be extended for a period of six (6) months from the date of the patient examination.

In consideration for the professional services rendered to me or at my request, by the Doctor, I agree to pay for said services to Dr. West or her assignee, at the time said services are rendered, or within five (5) days of treatment, if credit should be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

Further, I understand and acknowledge that photographs and images of me may be shown to other patients and doctors for treatment and educational purposes and I agree to the same.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

**I have read the above conditions of treatment and payment and agree to their content.**

\_\_\_\_\_ Date: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
*Electronic signature of patient, parent or responsible party*

**Summerlin Center for Aesthetic Dentistry**  
**Consent For Use and Disclosure of Health Information (HIPAA)**

*Section A: Patient Giving Consent*

Name of Patient: \_\_\_\_\_  
(PRINT)

*Section B: PATIENTS PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY*

**Purpose of Consent:** By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations.

**Notice of Privacy Practices:** You have the right to read our Notice of Privacy Practices before you decide to sign this Consent. Our notice provides a description of our treatment, payment activities and healthcare operations, of the uses and disclosures we may make of your protected health information. A copy of our Notice is available at your request in our office or on our website at [topsummerlindentist.com](http://topsummerlindentist.com). We encourage you to request a copy and read it carefully and completely before signing this consent. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact: David Gorczyca, Summerlin Center for Aesthetic Dentistry, Privacy Officer  
Address: 2095 Village Venter Circle, Suite 110, Las Vegas, NV 89134  
Phone: (702) 240-0400 Fax: (702) 242-0004

**Right to Revoke:** You will have the right to revoke this Consent at any time by providing our office with a written notice of your revocation submitted to the contact person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

**Consent:** I, the patient and/or representative\*, have had full opportunity to read and consider the contents of this consent form and your Notice of Privacy Practices. I understand by signing this Consent form, I am giving my consent to use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Electronic Signature: \_\_\_\_\_

Date: \_\_\_\_\_

\* If this Consent is signed by a personal representative on behalf of the patient, please complete the following:

Personal Representative Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.  
Include completed Consent in patient chart.