Gary Aglietti D.M.D. Ltd.
Elizabeth Park D.D. S.
501 S. Division St. Carson City, NV 89703
(775) 882 1195
Patient Information

Welcome to Our Office!

Patient Name _____ Birth Date_____ SS#_____
Home Address_____ City_____ Zip_____
Mailing address (if different)_____
Home Phone _____ Work phone _____ Ext ___ Cell_____
Employer _____ Position _____
List any family members who have been or are patients in this office_____
How did you hear about us? _____
Email Address_____
Emergency contact_____ **Phone**_____

Patient/Guardian/Responsible Party of Patient

Name_____ Relationship to Patient_____
Address_____ Home phone _____
work phone_____ Ext_____ Cell_____
Email address_____
Birth Date_____ SS# _____

Primary Insurance

Employer_____
Dental Insurance Company_____ Group#_____ ID#_____
Name of Policy Holder_____ DOB_____ SS#_____

Secondary Insurance

Employer_____
Dental Insurance Company_____ Group #_____ ID#_____
Name of Policy Holder_____ DOB_____ ID#_____

1) The undersigned hereby authorizes doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis of the patient's dental needs.
2) I also authorize doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment in connection with (name of patient) _____. I understand that using anesthetic agents embody a certain risk. Furthermore, I authorize and consent that doctor choose and employ such assistances as deemed fit to provide recommended treatment.
3). I understand that it is my responsibility to advice your office of any changes in the information contained on this form.

My signature also confirms that I have been given copies of the NOTICE OF PRIVACE PRACTICES AND TERMS AND CONDITIONS sheet regarding insurance, payment, and financial arrangements.

_____ _____
Print Name Date

_____ _____
Signature Relationship to patient

Patient Medical and Dental History

Are you having any discomfort at this time? _____ Y N
If YES, please describe _____
Do you see a dentist on a regular recall basis? Y N Last dental visit_____ Last x-rays_____
Have you ever had gum surgery?_____ If yes, when? _____Dentist?_____
Have you ever had your teeth straightened? _____ How often do you brush?_____
Floss? _____ Use a waterpic? _____ Use a toothpick? _____ Do your gums bleed? _____
Does food get stuck between your teeth? _____ Y N
Do you clench or grind your teeth? _____ Y N
Are you under a lot of stress or tension? _____ Y N
Are you having any problems with Headaches Difficulty chewing
Pain in /around ears Pain opening/closing mouth
Are you aware of any swelling or lumps in your mouth? _____ Y N
Are you in good health?_____ Y N
Name of physician_____ Phone_____ Last physical?_____
Are in under a physicians care now? _____ Y N
If yes, for what? _____
Have you ever had a serious injury, illness or operation?_____ Y N
Have you ever been hospitalized?_____ Y N
If yes, for what? _____
Are you taking any drugs or medicine? _____ Y N
If yes, for what?_____
Are you sensitive or allergic to any drugs?_____ Y N
If yes, what?_____
Are you allergic to LATEX? _____ Y N
Do you have, or ever had any of the following? (if YES, please circle)

Anemia	Stomach Ulcer	Glaucoma	Hepatitis, Jaundice or Live Disease
Heart Problems	Kidney Disease	Sinus Trouble	Difficulty Swallowing
Epilepsy	Stroke	Diabetes	Rheumatism or Arthritis
Herpes	Blood Disorders	Sleep Disorder	Fainting Spells or Seizures
Rheumatic Fever	Excessive Bleeding	Mental Disorders	Acquired Immune Deficiency
Tuberculosis	Snoring	High Blood Pressure	Tumors/Growths
Venereal Disease	Use Tobacco	Daytime Sleepiness	Artificial Prosthesis (implants)
Allergies	Night Sweats	Gasping for Breath	Radiation Treatment
Nervous Disorders	Asthma/Hay Fever	Respiratory Problems	1+ Alcoholic drinks per day

Have you had any heart surgery? _____ Y N
Do you have any disease, condition or problem not listed that you think I should know about? _____ Y N
If yes, what? _____
Have you had any joint replacement? _____ Y N
If yes, what? _____ When? _____
Do you need to take ANITBIOTICS before dental appointments? _____ Y N
Have you ever taken an appetite suppressant? Fenfluramine/Phentermine or Desfenfluramine(FenFen/Redux) Y N
(Women) Are you pregnant?_____ Y N
If yes, how many months?_____
(Women) Do you have any menstruation problems?_____ Y N

Park Dental Management Office Financial Policy

1. When insurance is not involved with treatment payment is due when services are rendered, we do not offer an in office monthly payment plan.

2. If you carry dental insurance, we will be collecting your yearly deductible and a patient portion on every visit. **If you're insurance has not paid your claim within 30 DAYS IT IS YOUR RESPONSIBILITY to contact your dental insurance carrier to make sure payment on your claim is being processed or PAY YOUR ACCOUNT IN FULL AND WAIT TO BE REIMBURSED.**

3. We will as an accommodation only, bill your insurance company for your charges incurred for treatment received. You agree that any sums so charged which are not paid by your insurance company remain your responsibility to pay.

4. I understand if I do not pay my account with Park Dental Management in full that my account may be assigned to a collection agency for collection.

5. I understand that if my account is assigned to a collection agency that the collection agency will charge a commission or fee equal to 50% of the amount I owe to Park Dental Management. I agree that if my account is assigned to a collection agency, that Park Dental Management may add the amount of the collection agency's commission or fee to the amount I owe Park Dental Management, and I agree to pay that additional amount.

6. I understand in addition of a collection agency's fee or commission to my unpaid balance may well result in my owing a sum substantially in excess of the amount owed for dental services, in the event this occurs I agree to pay all sums.

EXAMPLE;	Before collection action balance:	$10.00
	Collection Agency Fee added:	$ 5.00
	Balance w/collection fee added	**$ 15.00**

7. I understand and agree that in the event legal action is commenced to enforce my obligations hereunder, that I will pay court costs and reasonable attorney's fees.

Print Name _____ Date _____ Signature _____ Date _____

ACKNOWLEDGEMENT
OF
PRIVACY PRACTICES

Park Dental Management Company
501 S. Division Street
Carson City, NV 89701
(775)882-1195

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

- ☐ Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly
- ☐ Obtain payment from third-party payers for my health care services
- ☐ Conduct normal health care operations such as quality assessment and improvement activities

I have been informed of my dental provider's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices*. I understand that my dental provider has the right to change the *Notice of Privacy Practices* and that I may contact this office at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____ Date: _____

Signature: _____

Relationship to Patient: _____

Dependent family members also covered by this acknowledgement:

_____

_____

For Office Use Only:

We were unable to obtain the patient's written acknowledgement of our Notice of Privacy Practices due to the following reason:

- ☐ The patient refused to sign
- ☐ Communication barriers
- ☐ Emergency situation
- ☐ Other