LAKESIDE DENTAL

6490 S. McCarran Blvd. A-9 | Reno, NV 89509
Call Today! (775) 786-7718
Visit Us Online: LakesideDentalReno.com

Welcome!

The benefits of a healthy, happy smile are immeasurable! Our main goal is to help you achieve and maintain your maximum oral health and a smile you are proud to show off. Please fill out this form as completely as possible. We want to make sure that we are well informed about your medical history, current medications, and any other factor that might affect your dental health and treatment. The better we communicate, the better able we are to take great care of you.

ABOUT YOU

Today's Date: _____ How did you hear about us? _____

Name (First, Middle, Last): _____

I prefer to be addressed as: _____ Circle One: **Male** **Female**

Birthdate: _____ Age: _____ SS#: _____

Address: _____

City: _____ State: _____ Zip: _____

Email Address: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____

Employer: _____ Occupation: _____

Employer's Address: _____

City: _____ State: _____ Zip: _____

Circle One: **Single** **Married** **Widowed** **Divorced** **Separated** **Partnered**

Spouse's Name: _____

Spouse's Birthdate: _____ SS#: _____

Spouse's Employer: _____ Occupation: _____

When and where are the best times to reach you? _____

Other Family Members Seen by Us: _____

EMERGENCY CONTACT (Please specify someone who does not live in your household)

Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____

DENTAL INSURANCE

Do you have dental insurance coverage? **Yes** **No**

Person Responsible for Account (If other than yourself): _____

Dental Insurance Co. Name: _____

Dental Insurance Co. Address: _____

City: _____ State: _____ Zip: _____

Dental Insurance Co. Phone: _____

Group # (Plan, Local, or Policy#): _____

Insured's Name: _____ Relationship: _____

Insured's Birthdate: _____ SS#: _____

Insured's Home Phone: _____ Alt. Phone: _____

Insured's Employer: _____ Occupation: _____

ACKNOWLEDGEMENTS & SIGNATURES

I acknowledge that the information I give in this form is correct to the best of my knowledge, and I understand that this information will be held in the strictest confidence. I also understand that it is my responsibility to inform this office of any changes in my insurance or medical status.

Signature: _____

Date: _____

I understand that I will be required to pay my estimated portion of Dr. Alan Topham's fees at the time of treatment unless prior arrangements have been made. I also understand that I am ultimately responsible for payment of any and all services rendered, regardless of insurance reimbursement.

Signature: _____

Date: _____

MEDICAL HISTORY

Do you have a physician? **Yes** **No** Physician's Name: _____ Phone: _____

Date of Last Physical: _____ Current Physical Health: **Excellent** **Good** **Fair** **Poor** **Very Poor**

Are you currently under the care/supervision of a physician? **Yes** **No** Please Explain: _____

Are you currently taking any prescription medications? **Yes** **No** Please List Medications with Correlating Diagnosis: _____

_____

For Women: Are you currently taking any oral contraceptives (birth control pills)? **Yes** **No** Are you pregnant? **Yes** **No** Are you nursing? **Yes** **No**

Do you or have you ever used tobacco in any form? **Yes** **No** If yes, how much? _____ For how long? _____

ALLERGIES - Circle any and all of the following to which you are allergic:

Aspirin • Barbiturates/Sleeping Pills • Codeine • Dental Anesthetics • Erythromycin • Ibuprofen/Motrin • Jewelry/Metals • Latex • Percocet • Penicillin • Tetracycline • Vicodin

Please list any other medications and/or materials to which you think you are allergic: _____

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MEDICAL CONDITIONS

Have you ever had any of the following medical conditions? **Circle "Yes" or "No."**

Abnormal Bleeding	**Yes**	**No**	Frequent Headaches	**Yes**	**No**	Mitral Valve Prolapse	**Yes**	**No**
Alcohol or Drug Abuse	**Yes**	**No**	Glaucoma	**Yes**	**No**	Pacemaker	**Yes**	**No**
Anemia	**Yes**	**No**	Hay Fever	**Yes**	**No**	Psychiatric Problems	**Yes**	**No**
Arthritis	**Yes**	**No**	Heart Attack	**Yes**	**No**	Radiation Treatment	**Yes**	**No**
Artificial Bones/Joints/Valves	**Yes**	**No**	Heart Murmur	**Yes**	**No**	Rheumatic/Scarlet Fever	**Yes**	**No**
Asthma	**Yes**	**No**	Heart Surgery	**Yes**	**No**	Seizures	**Yes**	**No**
Blood Transfusion	**Yes**	**No**	Hemophilia	**Yes**	**No**	Shingles	**Yes**	**No**
Cancer/Chemotherapy	**Yes**	**No**	Hepatitis	**Yes**	**No**	Sickle Cell Disease/Traits	**Yes**	**No**
Colitis	**Yes**	**No**	Herpes/Fever Blisters	**Yes**	**No**	Sinus Problems	**Yes**	**No**
Congenital Heart Disease	**Yes**	**No**	High Blood Pressure	**Yes**	**No**	Stroke	**Yes**	**No**
Diabetes	**Yes**	**No**	HIV or AIDS	**Yes**	**No**	Thyroid Problems	**Yes**	**No**
Difficulty Breathing	**Yes**	**No**	Hospitalized for Any Reason	**Yes**	**No**	Osteoporosis	**Yes**	**No**
Emphysema	**Yes**	**No**	Kidney Problems	**Yes**	**No**	Tuberculosis/TB	**Yes**	**No**
Epilepsy	**Yes**	**No**	Liver Disease	**Yes**	**No**	Ulcers	**Yes**	**No**
Fainting Spells	**Yes**	**No**	Low Blood Pressure	**Yes**	**No**	Venereal Disease	**Yes**	**No**

Please explain any serious medical conditions you have ever had: _____

_____

DENTAL HISTORY

Why have you come to our office today? _____ Are you in pain? **Yes** **No** If yes, for how long? _____

Previous Dentist: _____ Phone: _____ Last Visit Date: _____

What was done? _____ Date of Last Cleaning: _____ Date of Last Dental X-rays: _____

Have you ever been told that you require antibiotics before dental treatment? **Yes** **No**

Do you have, or have you ever had any of the following conditions, ailments, or treatments? **Circle "Yes" or "No."**

Bad Breath	**Yes**	**No**	Food Collection Between Teeth	**Yes**	**No**	Orthodontic Treatment	**Yes**	**No**
Bleeding Gums	**Yes**	**No**	Foreign Objects in Mouth	**Yes**	**No**	Pain Around Ear	**Yes**	**No**
Blisters on Lips or in Mouth	**Yes**	**No**	Grinding Teeth	**Yes**	**No**	Pain When Brushing	**Yes**	**No**
Broken Fillings	**Yes**	**No**	Gums Swollen or Tender	**Yes**	**No**	Periodontal Treatment	**Yes**	**No**
Burning Sensation on Tongue	**Yes**	**No**	Jaw Pain	**Yes**	**No**	Sensitivity to Cold	**Yes**	**No**
Chew on Only One Side	**Yes**	**No**	Jaw Fatigue	**Yes**	**No**	Sensitivity to Heat	**Yes**	**No**
Clenching of Teeth	**Yes**	**No**	Lip or Cheek Biting	**Yes**	**No**	Sensitivity to Sweets	**Yes**	**No**
Clicking or Popping of Jaw	**Yes**	**No**	Loose Teeth	**Yes**	**No**	Sensitivity When Chewing	**Yes**	**No**
Dry Mouth	**Yes**	**No**	Mouth Breathing	**Yes**	**No**	Sores or Growths in Mouth	**Yes**	**No**

Have you ever had a serious/difficult problem associated with any previous dental work? **Yes** **No** Do you ever experience pain in your jaw joint (TMJ/TMD)? **Yes** **No**

How would you classify your current dental health? **Excellent** **Good** **Fair** **Poor** **Very Poor**

On a scale of 1-10, how would you rate your smile (10 being the best)? _____

Would you like whiter teeth? **Yes** **No** Would you like fresher breath? **Yes** **No** What else about your smile would you like to change? _____

Do you feel anxiety about dental treatment? **Yes** **No** On a scale of 1-10, how would you rate your anxiety (10 being the most anxious)? _____

On average, how many times a day do you brush? _____ How many times a week do you floss? _____ What type of bristles does your toothbrush have? **Soft** **Medium** **Hard**

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AUTHORIZATION AND RELEASE

Thank you for choosing Lakeside Dental for your dental care. We hope to work with you to help you achieve excellent oral health. While recognizing the benefits of a pleasing smile and teeth that function well, you should be aware that dental treatment, like treatment of any other part of the body, has inherent risks. These are seldom great enough to offset the benefits of treatment, but should be considered when making treatment decisions. Benefits of dental treatment include: relief of pain, the ability to chew properly and enjoy eating, and the confidence and social interaction that a pleasing smile can bring. Common risks associated with virtually any dental procedure include:

- Allergic reaction. Dental materials and medications may trigger allergic or sensitivity reactions.
- Long-term numbness (parasthesia). Local anesthesia, or its administration, while almost always adequate to permit comfortable care, can result in temporary, or in rare instances,permanent numbness.
- Muscle or joint tenderness: Holding one's mouth open for prolonged periods of time, such as during dental treatment, can result in muscle or jaw joint tenderness. In a predisposed patient, it can precipitate a TMJ disorder.
- Sensitivity in teeth or gums, infection, or bleeding.
- Swallowing or inhaling small objects.

We follow procedural guidelines that most often lead to clinical success, but as in any other pursuit in health care, not everything always turns out the way it is planned. We will do our best to ensure that it does. Please feel free to ask questions in regard to all dental procedures that are recommended to you for yourself and for your dependent(s).

My signature below indicates that I have read and understand the general risks associated with dental treatment.

____ ________________

Signature of patient or parent/guardian, if minor Date

AUTHORIZATION & RELEASE & PAYMENT OPTIONS

- I authorize Dr. Topham and Lakeside Dental to release any information including the diagnosis and the records of any treatment or examination rendered to me or my dependent during the period of such dental care to the third party payors and/or other health practitioners.
- I authorize and request my insurance company to pay directly to Dr. Topham and Lakeside Dental insurance benefits otherwise payable to me.
- I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependent(s).

PAYMENT OPTIONS

For your convenience, we offer the following methods of payments. Please check the option you prefer:

Cash ______ Personal Check ______ Visa ______ Master Card ______ CareCredit ______ I wish to discuss the financial policies ______

____ ________________

Signature of patient or parent/guardian, if minor Date

- -

CONSENT TO RELEASE / REQUEST DENTAL RECORDS (if applicable)

I, __________________________ (patient name), do hereby consent and authorize __________________________ (doctor's name) to disclose to Lakeside Dental information in my dental record, including current and previous dental records for other practitioners, hospitals, and/or clinics which are part of my record.

Patient Name: __________________________ Patient Date of Birth: __________________________

Reason for Transfer: ____

Authorization: I certify that this request has been made voluntarily and the information given above is accurate to the best of my knowledge.

Patient Signature: __________________________ Date: __________________________

Please send the following records to: Lakeside Dental • 3715 Lakeside Dr., Suite B • Reno, NV 89509 • lakesidedentalreno@yahoo.com

- Radiographs
- Periodontal Charting
- Progress Notes

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability & Accountability Act or 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.

- Obtain payment from third-party payors.

- Conduct normal healthcare operations such as quality assessments and physicians certification.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosers of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time 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 healthcare operations. I also understand 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: _____

Relationship to patient: _____

Signature: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date: _____ Initials: _____ Reason: _____