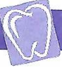
(PLEASE PRINT)



Patient Information

Date ____________________

SS/HIC/Patient ID # ____________________

Patient Name ____________________
Last Name

____
First Name Middle Initial

Address ____________________

E-mail ____________________

City ____________________

State ____________ Zip ____________

Sex ☐ M ☐ F Age ____________

Birthdate ____________________

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for ______ years

Patient Employer/School ____________________

Occupation ____________________

Employer/School Address ____________________

____

Employer/School Phone (_____) ____________________

Spouse's Name ____________________

Birthdate ____________________

SS# ____________________

Spouse's Employer ____________________

Whom may we thank for referring you? ____________________

Dental Insurance

Who is responsible for this account? ____________________

Relationship to Patient ____________________

Insurance Co. ____________________

Group # ____________________

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name ____________________

Birthdate ____________ SS# ____________

Relationship to Patient ____________________

Insurance Co. ____________________

Group # ____________________

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with ____________________ and assign directly to
Name of Insurance Company(ies)

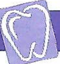
Dr. ____________________ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

____
Signature of Patient, Parent, Guardian or Personal Representative

____
Please print name of Patient, Parent, Guardian or Personal Representative

____________ ____________
Date Relationship to Patient



Phone Numbers

Home (______) ____________ Work (______) ____________ Ext ______ Alt. Phone (______) ____________

Spouse's Work (______) ____________ Best time and place to reach you ____________________

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name ____________________ Relationship ____________________

Phone (______) ____________________ Alt. Phone (______) ____________________

Dental History

Reason for today's visit ____________________

____

Former Dentist ____________________

City/State ____________________

Date of last dental visit ____________________

Date of last dental X-rays ____________________

Place a mark on "yes" or "no" to indicate if you have had any of the following:

Bad breath	☐ Yes	☐ No
Bleeding gums	☐ Yes	☐ No
Blisters on lips or mouth	☐ Yes	☐ No
Burning sensation on tongue	☐ Yes	☐ No
Chew on one side of mouth	☐ Yes	☐ No
Cigarette, pipe, or cigar smoking	☐ Yes	☐ No
Clicking or popping jaw	☐ Yes	☐ No
Dry mouth	☐ Yes	☐ No
Fingernail biting	☐ Yes	☐ No
Food collection between the teeth	☐ Yes	☐ No
Foreign objects	☐ Yes	☐ No
Grinding teeth	☐ Yes	☐ No
Gums swollen or tender	☐ Yes	☐ No
Jaw pain or tiredness	☐ Yes	☐ No
Lip or cheek biting	☐ Yes	☐ No
Loose teeth or broken fillings	☐ Yes	☐ No
Mouth breathing	☐ Yes	☐ No
Mouth pain, brushing	☐ Yes	☐ No
Orthodontic treatment	☐ Yes	☐ No
Pain around ear	☐ Yes	☐ No
Periodontal treatment	☐ Yes	☐ No
Sensitivity to cold	☐ Yes	☐ No
Sensitivity to heat	☐ Yes	☐ No
Sensitivity to sweets	☐ Yes	☐ No
Sensitivity when biting	☐ Yes	☐ No
Sores or growths in your mouth	☐ Yes	☐ No

How often do you floss? ____________

How often do you brush? ____________

Dental Registration and History

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Health History

Physician's Name ______________________________ Date of last visit______________

Have you ever used a bisphosphonate medication? Common brand names are Fosamax, Actonel, Atelvia, Didronel, Boniva. ☐ Yes ☐ No

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ☐ Yes ☐ No

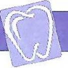
Place a mark on "yes" or "no" to indicate if you have had any of the following:

Condition	Yes	No
AIDS/HIV	☐ Yes	☐ No
Anemia	☐ Yes	☐ No
Arthritis, Rheumatism	☐ Yes	☐ No
Artificial Heart Valves	☐ Yes	☐ No
Artificial Joints	☐ Yes	☐ No
Asthma	☐ Yes	☐ No
Back Problems	☐ Yes	☐ No
Bleeding abnormally, with extractions or surgery	☐ Yes	☐ No
Blood Disease	☐ Yes	☐ No
Cancer	☐ Yes	☐ No
Chemical Dependency	☐ Yes	☐ No
Chemotherapy	☐ Yes	☐ No
Circulatory Problems	☐ Yes	☐ No
Congenital Heart Lesions	☐ Yes	☐ No
Cortisone Treatments	☐ Yes	☐ No
Cough, persistent or bloody	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No
Do you wear contact lenses?	☐ Yes	☐ No
Epilepsy	☐ Yes	☐ No
Fainting or dizziness	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No
Headaches	☐ Yes	☐ No
Heart Murmur	☐ Yes	☐ No
Heart Problems	☐ Yes	☐ No
Hepatitis Type ________	☐ Yes	☐ No
Herpes	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No
Jaundice	☐ Yes	☐ No
Jaw Pain	☐ Yes	☐ No
Kidney Disease	☐ Yes	☐ No
Liver Disease	☐ Yes	☐ No
Low Blood Pressure	☐ Yes	☐ No
Mitral Valve Prolapse	☐ Yes	☐ No
Nervous Problems	☐ Yes	☐ No
Pacemaker	☐ Yes	☐ No
Psychiatric Care	☐ Yes	☐ No
Radiation Treatment	☐ Yes	☐ No
Respiratory Disease	☐ Yes	☐ No
Rheumatic Fever	☐ Yes	☐ No
Scarlet Fever	☐ Yes	☐ No
Shortness of Breath	☐ Yes	☐ No
Sinus Trouble	☐ Yes	☐ No
Skin Rash	☐ Yes	☐ No
Special Diet	☐ Yes	☐ No
Stroke	☐ Yes	☐ No
Swollen Feet or Ankles	☐ Yes	☐ No
Swollen Neck Glands	☐ Yes	☐ No
Thyroid Problems	☐ Yes	☐ No
Tonsillitis	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No
Tumor or growth on head or neck	☐ Yes	☐ No
Ulcer	☐ Yes	☐ No
Venereal Disease	☐ Yes	☐ No
Weight Loss, unexplained	☐ Yes	☐ No

Women:

Are you pregnant? ☐ Yes ☐ No Due date______________ Are you nursing? ☐ Yes ☐ No

Taking birth control pills? ☐ Yes ☐ No



Medications

List any medications you are currently taking and the correlating diagnosis:

____

____

Pharmacy Name ______________________________

Phone (______) ______________________________

Allergies

☐ Aspirin

☐ Barbiturates (Sleeping pills)

☐ Codeine

☐ Iodine

☐ Latex

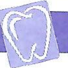
☐ Local Anesthetic

☐ Penicillin

☐ Sulfa

☐ Other______________

____



Updates (To be filled in at future appointments)

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions? ______________________________

Are you taking any new medications?__________ If so, what? ______________________________

Patient's Signature______________________________ Date______________

Doctor's Signature______________________________ Date______________

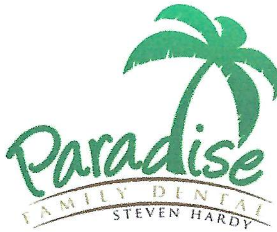
Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions? ______________________________

Are you taking any new medications?__________ If so, what? ______________________________

Patient's Signature______________________________ Date______________

Doctor's Signature______________________________ Date______________



Steven L. Hardy DDS
6825 Aliante Parkway
North Las Vegas, NV 89084
(702) 294-2739 (29-HARDY)
FAX: (702) 221-2741
www.ParadiseFamilyDental.com

Welcome to Paradise Family Dental, the practice of Steven L. Hardy D.D.S., a leading dental care practice in North Las Vegas, Nevada. We understand the importance of good dental hygiene and oral care and are committed to providing you the best care in a pleasant and relaxing environment. We offer a wide range of dental services including preventive, cosmetic, restorative, and reconstructive dentistry all in one convenient location with one dentist, Dr. Hardy. This is his only office which assures that your dental needs will be met consistently and timely. Using advanced technology, our experienced staff works together as a team to give you exceptional quality treatment from the moment you walk in for your initial visit.

Paradise Family Dental is dedicated to providing quality oral health care and we pride ourselves in being a patient-centered practice. Our goal is to improve the oral health of every individual we treat, which will improve his or her quality of life. We will do everything possible to make dental visits pleasant and relaxing for our patients so everyone leaves with a smile. We will be using the latest materials and equipment to assure quality and ease for our dental procedures and sterilization.

We expect our patients to be courteous, honest, and willing to become a team player in their dental treatment. We want you to understand not only what your treatment is, but why it is so important to your oral health. Through open communication and realistic expectations, pleasing results will be achieved.

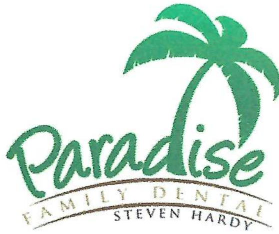
In an effort to eliminate the feeling of a "mass clinic" environment, appointment times are specifically scheduled for you and your needed dental treatment. We hope that you will feel the professional yet personal service we are rendering. For this reason, we ask that you please call 24 hours in advance if you need to reschedule your appointment. This allows us the opportunity to provide service to another patient who may be waiting to come in. If we do not have the 24 hour notice, you will be charged a Change of Appointment fee of $50.

Initialed____________

If you are bringing children with you that are not being seen for a scheduled appointment, we ask that you please also bring a baby sitter. Children are not to be left unattended in the waiting room and, for safety reasons, we can not have them in the operatories during your treatment. Along those same lines, a minor must have a parent or legal guardian present in the office at all times during their appointment.

Initialed____________

We thank you again for your interest in becoming a patient in our office. If you have any questions, please ask. **Signed**________________________ Date:__________



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Notice of Privacy Practices (NPP) Summary

This notice is effective as of 7/30/2022. In compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) we must notify you of our privacy policy. This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. You may request a copy of our unabridged notice at any time.

We recognize that our relationship with our patients is based on integrity and trust. We work hard to maintain your privacy and are very careful to preserve the private nature of our relationship with you. At the same time, the very nature of our business sometimes requires that we collect or share certain information about you with other health care providers, organizations and companies. We want you to be aware of how we handle personal information and the measures we take to protect it.

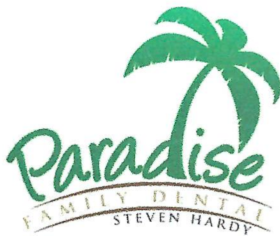
We may collect personal information about you from the following sources:

- From you or your authorized representative on forms, in interviews, or by other means;
- From medical, dental, or health care providers, governmental agencies, employers, or others
- From your insurance carriers, their affiliates or others.

How we may use and disclose health information about you:

- For your treatment
- For payments such as reimbursements, billing, collections, claim management, and determinations of eligibility and coverage to obtain payment
- Healthcare operations
- To individuals involved in your care or payment for your care
- Disaster relief
- When required by law
- Public health activities such as preventing/controlling disease, injury, or disability; reporting child abuse/neglect; report reactions/problems to medications, products, or devices; notifying a person who may have been exposed to a disease or condition; or notifying government if victim of abuse, neglect, or domestic violence
- National security
- When required by the secretary of HHS
- When required by Worker's Enforcement
- Health oversight activities like audits, investigations, inspections, and credentialing
- Judicial and administrative proceedings
- Research
- Coroners, medical examiners, or funeral directors
- Possible other uses with authorization

We require anyone to whom we disclose your personal information to protect its confidentiality and to use it solely for the purpose for which it is disclosed.



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Your rights regarding your health information:

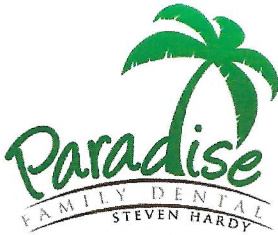
- Access by request of photocopies of health information
- To ask us to restrict our uses and disclosure practice of your Personal Health Information (PHI)
- To ask us to communicate with you in a confidential way
- To ask us to amend your health information
- To ask us for a list of disclosures of your health information
- Notification of a breach of security

We restrict access to nonpublic personal information about you to those employees who need to know that information to provide products and services to you. We maintain physical, electronic and procedural safeguards that comply with applicable regulatory standards to guard your nonpublic personal information.

We reserve the right to change this notice at any time in compliance with and as allowed by law. It is our intent to protect your nonpublic personal information. If you have questions or would like to register a complaint, please contact our office and ask to speak with Dr. Hardy.

Signature below is only an acknowledgement that you have received this Notice of our Privacy Practice.

Print Name:____________________ Signature:______________________ Date:________



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HIPAA CONSENT FORM

In compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I authorize Dr. Steven L. Hardy and his staff to contact me for the purpose of informing me of appointments, recall dates, or other reasons relating to my oral health. I authorize Dr. Hardy or his staff to leave voice or text messages on my home phone, cell phone, work phone, or e-mail if deemed necessary. I also authorize the use of letters to my home and work addresses if deemed necessary.

I agree to allow Dr. Hardy and his staff to share any information that they deem relevant for the purposes of billing for reimbursement of service provided.

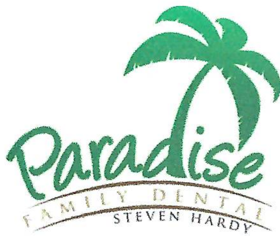
Furthermore, I understand that I am authorizing Dr. Hardy to release information related to my health and oral health care to my medical physicians and/or other health care providers.

I have received and read a copy of the HIPAA Notice of Privacy Practices (NPP).

I am aware that I may withdraw this authorization at any time with written notification.

______________________________ _________________________

Signature (or Parent/Guardian) Date



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DENTAL INSURANCE INFORMATION

Dental insurance is one of the most beneficial and most misunderstood factors in dental treatment today. This explanation will attempt to clear up many common misconceptions about dental insurance.

Dental insurance is a contract between the employer and the patient. It has NO CONNECTION at all to the provider of your dental treatment. The extent of coverage varies greatly from company to company, and sometimes even within a company. It has absolutely nothing to do with the level of service provided by the dentist or the fee charged for these services.

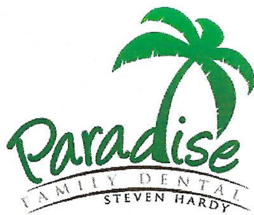
Here at our office, we will diagnose your oral health needs based on just that, your needs. Though we will try to help you maximize your insurance benefits, please understand that most insurance companies are in business because they make money and are not necessarily looking out for the best interest of your health or function. Typically the insurance company pays for the least expensive fix, which may or may not be advantageous for your oral health or situation. With that in mind, a part of Dr. Hardy's examination will include a discussion of treatment options to best meet your wants and needs which may or may not be a benefit of your specific insurance plan.

An often misunderstood term used by many insurance companies is "UCR". This is an arbitrary fee ceiling at which the insurance company will stop reimbursement. After this ceiling, coverage for a particular procedure will cease. Again, this has nothing to do with the fee charged, but with the level of coverage negotiated by your employer.

We will make every effort possible to assist you with your particular insurance coverage. Although it is not required, we will prepare and submit your insurance claim form at no cost as a courtesy for you, our patient. The estimated patient share will be due at time of treatment unless prior arrangements have been made. Should our estimate of patient share be too high, a refund will be made at the time of payment from the insurance company. Likewise, if the estimate was low, the remainder will be due at that time.

If you have any further questions concerning dental insurance, please let us know and we will be happy to discuss them with you.

Received by:______________________________ Date:______________



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DENTAL TREATMENT CONSENT FORM

Please read and initial the items checked below **Patient Name**__________

WORK TO BE DONE

I understand that I am having the following work done: Fillings______ Extractions________ Impacted teeth removed _______ Root Canals _________ FMX/Exam ____X____ Other _________

(Initials _________)

DRUGS AND MEDICATIONS

I understand that antibiotics and analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction)

(Initials _________)

CHANGES IN TREATMENT PLAN

I understand that during treatment it may be necessary to change of 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 Dr. Hardy to make any/all changes and additions as necessary.

(Initials _________)

REMOVAL OF TEETH

Alternatives to removal have been explained to me (root canal therapy, crowns, and periodontal surgery, ect.) and I authorize Dr. Hardy to remove the following teeth ___________________________ and any others necessary for reasons in paragraph #3. I understand that 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 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.

(Initials___________)

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 will be the "teeth in wax" try-in visit. I understand that most dentures require relining approximately three to twelve months after initial placement. The cost for this procedure is not included in the initial denture fee.

(Initials__________)

PERIORDONTAL LOSS (TISSUE AND BONE)

I understand that I have a serious condition, causing gum and bone inflammation or loss and that it can lead to the loss of my teeth. Alternative treatment plans have been explained to me, including gum surgery, replacements and/or extractions. I understand that undertaking any dental procedures may have a future adverse effect on my periodontal condition.

(Initials _________)

I understand that dentistry is not an exact science and that, therefore, reputable practitioners cannot fully guarantee results. 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 questions. My questions have been answered to my satisfaction. I consent to the proposed treatment.

Signature of Patient ____ Date__________

Signature of Parent/Guardian if patient is a minor____________________________ Date__________