Divine Dental

We would like to get to know you better!

PATIENT Name: _____ Male ⬭ Female ⬭ Birthdate: ____/_____/_____

Address: _____ City: _____ State: _____ Zip code: _____

Cell Phone: _____ Home: _____ E-Mail: _____

SS #: _____-_____-_____ Occupation: _____ Employer: _____

If patient is a minor,

Parent's Name: _____ Parent's DOB: _____/_____/_____ SS #: _____-_____-_____

Parent's occupation: _____ Parent's employer: _____

Spouse's Name: _____ Spouse's DOB: _____/_____/_____ SS #: _____-_____-_____

Spouse's occupation: _____ Spouse's employer: _____

INSURANCE

Name of carrier: _____ Group #: _____ Phone #: _____

Name of Subscriber: _____

Name of additional carrier: _____ Group #: _____ Phone #: _____

Who referred you to our office: _____

Date of last dental visit: _____ Treatment performed: _____

Are you sensitive to:	Yes	No
Heat	⬭	⬭
Cold	⬭	⬭
Sweets	⬭	⬭
Biting Pressure	⬭	⬭
Does food get caught between teeth?	⬭	⬭
Do you have an unpleasant taste or odor?	⬭	⬭
Do your gums bleed while brushing?	⬭	⬭
Are you concerned about finances?	⬭	⬭
Have you ever had botox or facial fillers?	⬭	⬭
Are you dissatisfied with the appearance of your teeth?	⬭	⬭
If yes, explain:		
Do you have any fears of the dentist?	⬭	⬭
Are you having any areas of concern today?	⬭	⬭
If yes, explain: _____		

I Understand that I am responsible for payment of my account within 90 days after treatment

Patient Signature: _____ Date: _____/_____/_____

Divine Dental

Dr. Rachel Mismas

We would like to get to know you better!

Patient Name: _____ Birthdate: ____/_____/_____ Today's Date: _____/_____/_____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have or medication that you may be taking could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	Yes	○	No	○
Have you ever been hospitalized or had a major operation?	Yes	○	No	○
Have you ever had a serious head or neck injury?	Yes	○	No	○
Are you taking any medications, pills or drugs?	Yes	○	No	○
Do you take or have taken Phen-Fen or Redux?	Yes	○	No	○
Have you ever taken bone replacement medications such as Foxamax or Boniva?	Yes	○	No	○
Are you on a special diet?	Yes	○	No	○
Do you use tobacco?	Yes	○	No	○
Do you use controlled substances?	Yes	○	No	○

Women: Are you…

○ Pregnant ○ Nursing ○ Taking Oral Contraceptives?

Are you allergic to the following?

○ Aspirin	○ Penicillin	○ Codeine	○ Acrylic
○ Metal	○ Latex	○ Sulfa Drugs	○ Local Anesthetics

Other? If Yes, _____

Do you have or have you had any of the following?

	○ Cortisone Medication	○ Hemophilia	○ Radiation Treatments
○ Alzheimer's	○ Diabetes	○ Hepatitis A	○ Recent Weight Loss
○ Anaphylaxis	○ Drug Addition	○ Hepatitis B or C	○ Renal Dialysis
○ Anemia	○ Easily Winded	○ Herpes	○ Rheumatic Fever
○ Angina	○ Emphysema	○ High Blood Pressure	○ Rheumatism
○ Arthritis/Gout	○ Epilepsy or Seizures	○ High Cholesterol	○ Scarlet Fever
○ Artificial Heart Valve	○ Excessive Bleeding	○ Hives or Rash	○ Shingles
○ Artificial Joint	○ Excessive Thirst	○ Hypoglycemia	○ Sickle Cell Disease
○ Asthma	○ Fainting Spells/Dizziness	○ Irregular Heartbeat	○ Sinus Trouble
○ Blood Disease	○ Frequent Cough	○ Kidney Problems	○ Spina Bifida
○ Blood Transfusion	○ Frequent Diarrhea	○ Leukemia	○ Stomach/ Intestinal Disease
○ Breathing Problems	○ Frequent Headaches	○ Liver Disease	○ Stroke
○ Bruise Easily	○ Genital Herpes	○ Low Blood Pressure	○ Swelling of Limbs
○ Cancer	○ Glaucoma	○ Lung Disease	○ Thyroid Disease
○ Chemotherapy	○ Hay Fever	○ Mitral Valve Prolapse	○ Tonsilitis
○ Chest Pains	○ Heart Attack/Failure	○ Osteoporosis	○ Tuberculosis
○ Cold Sores/Fever Blisters	○ Heart Murmur	○ Pain in Jaw Joint	○ Tumors
○ Congenital Heart Disorder	○ Heart Pacemaker	○ Parathyroid Disease	○ Ulcers
○ Convulsions	○ Heart Trouble/Disease	○ Psychiatric Care	○ Venereal Disease

Have you ever had any serious illness not listed above? Yes ○ No ○

Comments: _____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature _____ Date: _____/_____/_____

NOTICE OF PRIVACY PRACTICES

Divine Dental

Dr. Rachel Mismas
7035 W Ann Rd #110, Las Vegas, NV 89130
www.divinedentallv.com
702-396-2929

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.

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This notice describes how we protect your health information and what rights you have regarding it.

TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

The most common reason why we use or disclose your health information is for treatment payment or health care operations.

- Treatment purposes: setting up an appointment, examining your teeth, prescribing medications and faxing them to be filled, referring you to another doctor for health care services, or getting copies of your health information from another professional.
- Payment: preparing and sending bills or claims, collecting unpaid amounts (either ourselves or through a collection agency or attorney).
- Health care operations (those administrative or managerial functions that we do in order to run our office): financial or billing audits, internal quality assurance, personnel discussions, participation in managed care plans, defense of legal matters, business planning, & outside storage of our records.

We routinely use your health information inside our office for these purposes without any special permission. If we need to disclose your health information outside of our office for these reasons, we will ask you for special written permission.

USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

- When a state or federal law mandates that certain health information be reported for a specific purpose;
- Uses or disclosures for public health purposes such as contagious disease reporting, investigation or surveillance, and notices to and from the federal Food and Drug Administration regarding drugs or medical devices and/or health related research;
- Disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence;
- Uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws;
- Disclosures for law enforcement purposes such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else;
- Incidental disclosures that are an unavoidable by-product of permitted uses or disclosures;
- Disclosures to “business associates” who perform health care operations for us and who commit to respect the privacy of your health information.

Unless you object, we will also share relevant information about your care with your family or friends who are helping you with your dental care.

APPOINTMENT REMINDERS

We may text, call or write to remind you of scheduled or routine appointments. We may also call, text or write to notify you of other treatments or services available at our office that might help you. Unless you tell us otherwise, we will text or mail you an appointment reminder on a post card, and/or leave you a reminder message on your cell phone, home answering machine or with someone who answers your phone if you are not at home.

OTHER USES AND DISCLOSURES

We will not make any other uses or disclosures of your health information unless you sign a written “authorization form”. The content of an “authorization form” is determined by federal law. Sometimes you may initiate the authorization process if it is your idea or ours. If we initiate the process and ask you to sign an authorization form, you do not have to sign it. If you do not sign the authorization, we cannot make the use or disclosure. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it. Revocations must be in writing. Send them to the office contact person at the beginning of this notice.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

The law gives you many rights regarding your health information. You can:

- Ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or health care operations. We do not have to agree to do this. To ask for a restriction, send a written request to our office attn: Dr. Mismas, confidential restrictions.
- Ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address or by using Email to your personal Email address. We will accommodate these requests if they are reasonable. If there is an added cost to these communications, you may be obligated to pay an additional fee. If you want to ask for confidential communications, send a written request attn: Dr. Mismas, confidential communications.
- Ask to see or to get photocopies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying. For the most part, however, you will be able to review or have a copy of your health record within 30 days of asking us (or 60 days if the information is stored off-site). You may have to pay for photocopies in advance. If we deny your request, we will send you a written explanation, and instructions how to get an impartial review of our denial if one is legally available. By law, we can have one 30-day extension. If you want to review or get photocopies of your health information, send a written request to our office attn: Dr. Mismas, copy of health information.
- Get a list of the disclosures that we have made of your health information within the past 6 years (or a shorter period if you want). By law, the list will not include: disclosures for purposes of treatment, payment or health care operations; disclosures with your authorization; incidental disclosures; disclosures required by law; and some other limited disclosure. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law we can have one 30 day extension of time if we notify you of the extension in writing. If you want a list, send a written request to the office attn: Dr. Mismas, Health Disclosure List.
- Get additional paper copies of this Notice of Privacy Practices upon request. It does not matter whether you got one electronically or in paper form already. If you want additional paper copies, send a written request to this office attn: Dr. Mismas, Notice of Privacy Practices Request.

OUR NOTICE OF PRIVACY PRACTICES

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change at any time as allowed by law. If we change this notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office, have copies available in our office, and post it on our website.

COMPLAINTS

If you believe we have not properly respected the privacy of your health information, you are free to complain to us or the US Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. F you want to complain to us, send a written complaint to our office attn: Dr. Mismas, complaints. If you prefer, you can discuss your complaint in person or by phone or email us through our website's contact page.

FOR MORE INFORMATION

If you want more information about our privacy practices, call or visit the office contact person at the address or phone number shown at the beginning of this Notice.

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Divine Dental

Dr. Rachel Mismas
7035 W Ann Rd #110, Las Vegas, NV 89130
www.divinedentallv.com
702-396-2929

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of Dr. Rachel Mismas's Notice of Privacy Practices.

Patient Name: ____ Date: ________/________/ ________

Signature: ____

Divine Dental

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FINANCIAL POLICY

Our primary goal is not to allow the cost of treatment prevent you from benefitting from the quality of care you need or desire. In our office, we strive to maximize your insurance benefits and make any remaining balance easily affordable.

Our fees are based on the quality materials we use and the time, effort and skill required in performing your needed treatment. We charge what is the usual and customary for our area. We will assist you with your benefit eligibility before treatment to help you calculate your costs and maximize your insurance. We will be sensitive to your financial circumstances and do everything possible to help you achieve oral health. Ultimately, however, you are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

We are happy to submit the claims necessary to see that you receive the full benefits of your coverage; however we cannot guarantee any estimated coverage. Because the insurance policy is an agreement between you and the insurance company, we ask that all patients be directly responsible for all charges. Please know that we will do everything possible to see that you receive the full benefits of your policy. If there are any complications, we will assist you with any information you may need.

We accept the following forms of payment: cash, check, Visa, and MasterCard. We offer a 5% discount for all treatment over $2000 paid in cash or check. In addition, we offer CareCredit, a patient payment program offering a full range of No Interest and Extended Payment Plans for treatment fees from $1 and up.

Payment for services is due at the time services are rendered unless prior arrangements have been made. Checks that are returned to our office from your financial institution are subject to a $35.00 returned check fee. This fee covers the processing fees that are charged to our office by the bank.

We would be happy to discuss our charges and how they relate to your particular situation. We also realize that temporary financial situations may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account. Most often, financial misunderstandings can be managed with a phone call. Please feel free to contact our wonderful staff to discuss concerns you may have.

DEPOSIT POLICY: Due to the extensive amount of time our staff and doctors devote to preparing and reserving uninterrupted time for reservations over 2 hours, we require a deposit of half of the treatment fee to make your reservation.

RESCHEDULING/CHANGE IN SCHEDULE POLICY: Our practice is dedicated to quality care and exceptional service. Our doctors and team spend extensive amounts of time preparing for your visit. Broken and missed appointments create scheduling problems for our team as well as other clients. If you find that you must change your appointment, we require a minimum of 48 hours' notice so that we may make every effort to accommodate other clients. If proper notice is not received, a fee of $50 will be charged for every hour of allotted time cancelled to your credit card on file.

I have read and agree to the Financial, Deposit and Cancellation Policy of Divine Dental.

Name: _____ Date: _____/_____/_____

Signature: _____