Welcome

Thank you for choosing our practice. Please fill out this form as completely as you can. If you have any questions we will be glad to help. (Please print)

Silverado Family Dental ♦ 9777 Bermuda Road, Suite 100 ♦ Las Vegas, NV 89183 ♦ 702-699-5551

PATIENT INFORMATION

Name:________________________________ [ ]Dr. [ ]Mr. [ ]Mrs. [ ]Ms. [ ]Rev. [ ]Other:____________
First MI Last

Address:________________________________ Occupation:____________________ [ ]Male [ ]Female

City:______________ State:__________ Zip:________ Hm#(___)____________________

Employer:____ Wk#(___)__________ Ext:______

Are you: [ ]Minor [ ]Married [ ]Single [ ]Divorced [ ]Widowed [ ]Separated Cell# (___)____________________

DOB:____/____/______ SS#:____________________ Email:______________@____________

Spouse's Name:____
First MI Last

Spouse Occupation:____ Wk#(___)__________ Ext:______

Is patient a full-time student? [ ]No [ ]Yes: Name of School:________________________________

Responsible Party (if different than patient)

Name:____
First MI Last

Address:____

City:______________ State:__________ Zip:__________

Hm#: (___)________________________________

Wk#: (___)____________________ Ext:__________

DOB:____/____/______ SS#:____________________

Relationship:______________________________

Your preferences

Do you prefer to receive calls from our office at:
[ ]Home [ ]Work [ ]Cell

How do you wish to be addressed by our staff?
____

Whom may we thank for referring you?
____

INSURANCE INFORMATION

MEDICAL INSURANCE:

Subscriber's Name:______________________________ Relationship to patient:____________________

DOB:____/____/______ Subscriber's SS#:____________________

Insurance Company:______________________________ Policy #:__________ Group#:____________

SUPPLEMENTAL INSURANCE (DENTAL):

Insured Name:______________________________ Relationship to patient:____________________

Address:______________________________ City:__________ State:________ Zip:________

DOB:____/____/______ SS#:____________________ Employer:____________________________

Insurance Company:______________________________ Group #:__________ Eff. Date:____________

DO YOU HAVE ADDITIONAL DENTAL INSURANCE? [ ]Yes [ ]No If yes, please complete the following:

Insured Name:______________________________ Relationship to patient:____________________

Address:______________________________ City:__________ State:________ Zip:________

DOB:____/____/______ SS#:____________________ Employer:____________________________

Insurance Company:______________________________ Group #:__________ Eff. Date:____________

CONFIDENTIAL

Medical History and Consent

Name:____ Date:_______________________________

Although dental personnel treat the area in and around your mouth, your mouth is a part of your entire body. Health conditions or problems that you may currently have or may have had in the past, or medications that you are currently taking, could have an important interrelationship with the treatment you will receive. Thank you for answering the following questions.

Allergies

Acrylics Y N
Anaphalaxis Y N
Aspirin/NSAIDS Y N
Clindamycin Y N
Codeine Y N
Latex Y N
Local Anesthetics Y N
Penicillin Y N
Metal Y N
Sulpha Y N
List other known allergies:
____
____
____

Cardiovascular

Artificial Heart Valve Y N
Coronary Artery Disease Y N
Chest Pain or Angina Y N
Congestive Heart Failure Y N
Heart Attack Y N
Heart Murmur Y N
High Blood Pressure Y N
High Cholesterol Y N
Irregular Heart Beat Y N
Low Blood Pressure Y N
Mitral Valve Prolapse Y N
Pacemaker Y N
Tachycardia Y N

Endocrine

Diabetes Y N
Gout Y N
Hormonal Change Y N
Thyroid Problems Y N

Eyes, Ears, Nose and Throat

Change in Hearing Y N
Change in Vision Y N
Dysphagia Y N
Ear Pain Y N
Glaucoma Y N
Hay Fever Y N
Nasal Obstruction Y N
Nose Bleeding Y N
Sinus Problems Y N
Tonsillectomy Y N
Tinnitus (Ringing in Ears) Y N

Gastrointestinal

Acid Reflux Y N
GERD Y N
Soft or Special Diet Y N
Ulcers Y N

Genitourinary

Frequent Urination Y N
Kidney Disease Y N
Nocturia Y N

General

Current Weight:___________Lbs
Height:__________Ft _______In
Cancer Y N
Type:_________________
Head/Neck Radiation Y N
Fatigue/Tired Y N
General Weakness Y N
Headaches Y N
HIV/AIDS Y N
Knee/Hip Replacement Y N
Liver Problems Y N
Recent Trauma/Injury Y N
Rheumatic Fever Y N
Radiation Treatment Y N
Weight Change Y N

Hematological

Bleeding Problems Y N
Hepatitis Y N

Oral

Bleeding Gums Y N
Dry Mouth Y N
Jaw Problems (TMJ) Y N
Clicking Y N
Pain Y N
Difficulty Swallowing Y N
Difficulty Chewing Y N
Orthodontics/Invisalign Y N
Periodontal Disease Y N
Teeth Clenching Y N
Teeth Grinding Y N
Tooth Pain Y N
Wisdom Teen Extraction Y N
Wearing Removable Teeth Y N
Do you required antibiotics before dental procedures: Y N

Musculoskeletal

Back Pain Y N
Fibromyalgia Y N
Joint Pain Y N
Osteoporosis Y N
Osteopena Y N
Pagets Disease Y N
Have you taken Bisphophonates:
Pamidronate (Aredia) Y N
Neridronate Y N
Olpadronate Y N
Alendronate (Fosamax) Y N
Ibandronate (Boniva) Y N
Residronate (Actonel) Y N
Zolentronate (Zometa Reclast) Y N
Denosumab (Prolia) Y N

Neurological

Alzheimer's Disease Y N
Dizziness Y N
Fainting Y N
Memory Loss Y N
Multiple Sclerosis (MS) Y N
Muscle Weakness Y N
Seizures Y N
Stroke Y N
Tingling/Numbness Y N
Trigeminal Neuralgia Y N
Tremor Y N

Psychiatric

ADD/ADHD Y N
Anxiety Y N
Chemical Dependency Y N
Depression Y N
Eating Disorders Y N
Excessive Stress Y N
Memory Problems Y N

Respiratory

Asthma Y N
Bronchitis Y N
Breathing Problems Y N
Chest Pressure Y N
Congestion Y N
Dyspnea (Shortness of Breath) Y N
Emphysema Y N
Orthopnea Y N
Pneumonia Y N
Pulmonary Embolism Y N
Tuberculosis Y N

Sleep

Daytime Sleepiness Y N
Morning Headaches Y N
Obstructive Sleep Apnea Y N
Do you use CPAP Y N
How often:____________
Have you been told you snore: Y N

Social History

Do You Smoke: Y N
Packs Per Day:__________
Use Smokeless Tobacco Y N
Consume Alcohol: Y N
Drinks Per Day/Week/Month:_________
Use Recreational Drugs: Y N

List any medications you are taking:

Medication Dosage/Freq. Prescriber Reason

1. ____
2. ____
3. ____
4. ____
5. ____
6. ____

List any surgeries or hospitalizations you have had:

Date/Year Surgery Surgeon Reason

List and detail any medical condition or history not listed above:

Primary Physician's Name:_________________________ Physician's Phone #:_________________________

Are you under the care of other doctors? If so, please list:

Doctor	Phone Number	Reason

GENERAL CONSENT TO DIAGNOSE AND TREAT: The undersigned hereby authorizes Dr. R. Garth Harris, D.D.S. to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate to make a through diagnosis of the undersigned patient's dental condition and needs. I authorized Dr. R. Garth Harris, D.D.S. to perform any and all forms of treatment, medication, and therapy that maybe necessary and further consent that Dr. R. Garth Harris, D.D.S. choose and employ such assistance as deemed necessary. I understand that the use of local anesthetics agents embodies certain risk and consent to their use as deemed appropriate by Dr. R. Garth Harris, D.D.S. To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect or incomplete information can be dangerous to my/the patient's health. It is my responsibility to inform the dental office of any change in medical health status.

FINANCIAL CONSENT: I understand that responsibility for payment of services provided in this office for myself and my dependents(s) is mine, due and payable at the time services are rendered. I understand that I am responsible for any portion of fees for services rendered not covered by my dental or medical insurance (if any). I acknowledge that I am responsible for all fees necessary to collect my account. I authorize Dr. R. Garth Harris, D.D.S. and his staff to verify insurance coverage, if any, to submit claims and provide my insurance company with information required for a claim, to assign benefits payable to him, and to handle any necessary claim appeal(s) on my behalf.

Consent (adult):
Name of Patient:_________________________ Signature of Patient:_________________________ Date:_________

Consent (minor):
Name of Parent/Guardian:____________________ Signature of Parent/Guardian:____________________ Date:_________

Notice of Privacy Practices

Patient privacy is important to our practice. We are required by law to maintain the privacy of Protected Health Information ("PHI") and to provide individuals with notice of our legal duties and privacy practices with respect to PHI. By signing below you are acknowledging receiving notice of our practices' policies and your rights regarding PHI. I allow release of pertinent medical records to my insurance company (if applicable) and my other medical providers.

_____________________________ Date:___________

Signature of Patient