



PATIENT INFORMATION/REGISTRATION

Date: _____

Name: _____
Last First Middle

Address: _____

City State Zip code

Home Phone: WK Phone:

Cell Phone: E-Mail:

Birthday: _____ Male / Female: _____

Marital Status: M S D W Spouse's Name: _____

Social Security Number:

Drivers License# _____ State: _____

Occupation: _____ Employer: _____

How did you hear about us: _____

RESPONSIBLE PARTY:

If it is different than the patient

Name: _____
Last First Middle

Address: _____

City State Zip code

Home Phone: WK Phone:

Cell Phone: E-Mail:

Birthday: _____ Male / Female: _____

Marital Status: M S D W Spouse's Name: _____

Social Security Number:

Insurance Company: _____

Phone Number On Card: _____

How Long Have You Had This Insurance: _____

Secondary Insurance: _____

Phone Number On Card: _____

How Long Have You Had This Insurance: _____



MEDICAL HISTORY

Patient Name: _____

Although dental personnel primarily treat the area in an around your mouth, you 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 If yes, please explain: _____
- Have you ever been hospitalized or had a major operation: Yes No If yes, please explain: _____
- Have you ever had a serious head or neck injury? Yes No If yes, please explain: _____
- Are you taking any medications, pills, or drugs? Yes No _____
- Do you take, or have you taken, Phen-Fen or Redux 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 / Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No

Are you allergic to any of the following?

- Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics
- Other If yes, please explain: _____

PLEASE DO NOT RUN LINE THROUGH ALL THE "NO'S". YOU MUST INDIVIDUALLY CHECK THE BUBBLE WHETHER IT IS "YES" OR "NO". IF YOU FAIL TO DO SO, YOU WILL BE REQUIRED TO FILL OUT A NEW MEDICAL HISTORY FORM.

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

- | | | | |
|--|--|--|---|
| AIDS/HIV Positive <input type="radio"/> Yes <input type="radio"/> No | Cortisone Medicine <input type="radio"/> Yes <input type="radio"/> No | Hemophilia <input type="radio"/> Yes <input type="radio"/> No | Renal Dialysis <input type="radio"/> Yes <input type="radio"/> No |
| Alzheimer's Disease <input type="radio"/> Yes <input type="radio"/> No | Diabetes <input type="radio"/> Yes <input type="radio"/> No | Hepatitis A <input type="radio"/> Yes <input type="radio"/> No | Rheumatic Fever <input type="radio"/> Yes <input type="radio"/> No |
| Anaphylaxis <input type="radio"/> Yes <input type="radio"/> No | Drug Addiction <input type="radio"/> Yes <input type="radio"/> No | Hepatitis B or C <input type="radio"/> Yes <input type="radio"/> No | Rheumatism <input type="radio"/> Yes <input type="radio"/> No |
| Anemia <input type="radio"/> Yes <input type="radio"/> No | Easily Winded <input type="radio"/> Yes <input type="radio"/> No | Herpes <input type="radio"/> Yes <input type="radio"/> No | Scarlet Fever <input type="radio"/> Yes <input type="radio"/> No |
| Angina <input type="radio"/> Yes <input type="radio"/> No | Emphysema <input type="radio"/> Yes <input type="radio"/> No | High Blood Pressure <input type="radio"/> Yes <input type="radio"/> No | Shingles <input type="radio"/> Yes <input type="radio"/> No |
| Arthritis/Gout <input type="radio"/> Yes <input type="radio"/> No | Epilepsy or Seizure <input type="radio"/> Yes <input type="radio"/> No | Hives or Rash <input type="radio"/> Yes <input type="radio"/> No | Sickle Cell Disease <input type="radio"/> Yes <input type="radio"/> No |
| Artificial Heart Valve <input type="radio"/> Yes <input type="radio"/> No | Excessive Bleeding <input type="radio"/> Yes <input type="radio"/> No | Hypoglycemia <input type="radio"/> Yes <input type="radio"/> No | Sinus Trouble <input type="radio"/> Yes <input type="radio"/> No |
| Artificial Joint <input type="radio"/> Yes <input type="radio"/> No | Excessive Thirst <input type="radio"/> Yes <input type="radio"/> No | Irregular Heartbeat <input type="radio"/> Yes <input type="radio"/> No | Spinal Bifida <input type="radio"/> Yes <input type="radio"/> No |
| Asthma <input type="radio"/> Yes <input type="radio"/> No | Fainting Spells/Dizziness <input type="radio"/> Yes <input type="radio"/> No | Kidney Problems <input type="radio"/> Yes <input type="radio"/> No | Stomach/Intestinal Disease <input type="radio"/> Yes <input type="radio"/> No |
| Blood Disease <input type="radio"/> Yes <input type="radio"/> No | Frequent Cough <input type="radio"/> Yes <input type="radio"/> No | Leukemia <input type="radio"/> Yes <input type="radio"/> No | Stroke <input type="radio"/> Yes <input type="radio"/> No |
| Blood Transfusion <input type="radio"/> Yes <input type="radio"/> No | Frequent Diarrhea <input type="radio"/> Yes <input type="radio"/> No | Liver Disease <input type="radio"/> Yes <input type="radio"/> No | Swelling of Limbs <input type="radio"/> Yes <input type="radio"/> No |
| Breathing Problem <input type="radio"/> Yes <input type="radio"/> No | Frequent Headaches <input type="radio"/> Yes <input type="radio"/> No | Low Blood Pressure <input type="radio"/> Yes <input type="radio"/> No | Thyroid Disease <input type="radio"/> Yes <input type="radio"/> No |
| Bruise Easily <input type="radio"/> Yes <input type="radio"/> No | Genital Herpes <input type="radio"/> Yes <input type="radio"/> No | Lung Disease <input type="radio"/> Yes <input type="radio"/> No | Tonsillitis <input type="radio"/> Yes <input type="radio"/> No |
| Cancer <input type="radio"/> Yes <input type="radio"/> No | Glaucoma <input type="radio"/> Yes <input type="radio"/> No | Mitral Valve Prolapse <input type="radio"/> Yes <input type="radio"/> No | Tuberculosis <input type="radio"/> Yes <input type="radio"/> No |
| Chemotherapy <input type="radio"/> Yes <input type="radio"/> No | Hay Fever <input type="radio"/> Yes <input type="radio"/> No | Pain in Jaw Joints <input type="radio"/> Yes <input type="radio"/> No | Tumors or Growths <input type="radio"/> Yes <input type="radio"/> No |
| Chest Pains <input type="radio"/> Yes <input type="radio"/> No | Heart Attack/Failure <input type="radio"/> Yes <input type="radio"/> No | Parathyroid Disease <input type="radio"/> Yes <input type="radio"/> No | Ulcers <input type="radio"/> Yes <input type="radio"/> No |
| Cold Sores/Fever Blisters <input type="radio"/> Yes <input type="radio"/> No | Heart Murmur <input type="radio"/> Yes <input type="radio"/> No | Psychiatric Care <input type="radio"/> Yes <input type="radio"/> No | Venereal Disease <input type="radio"/> Yes <input type="radio"/> No |
| Congenital Heart Disorder <input type="radio"/> Yes <input type="radio"/> No | Heart Pace Maker <input type="radio"/> Yes <input type="radio"/> No | Radiation Treatments <input type="radio"/> Yes <input type="radio"/> No | Yellow Jaundice <input type="radio"/> Yes <input type="radio"/> No |
| Convulsions <input type="radio"/> Yes <input type="radio"/> No | Heart Trouble/Disease <input type="radio"/> Yes <input type="radio"/> No | Recent Weight Loss <input type="radio"/> Yes <input type="radio"/> No | |

Have you ever had any serious illness not listed above? Yes No If yes, please explain: _____

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 statue.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____



**If you are taking any medications
Please list them and what they are for:
PLEASE PRINT LEGIBLE**

Patient's name: _____ **Date:** _____

MEDICATION

CONDITION

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

7. _____

8. _____

9. _____

10. _____



DENTAL HISTORY

So we can provide you with the best possible care please complete this dental history form.
All of the information is completely confidential.

Patient's name: _____ Date: _____

What is the reason for today's visit? _____

Date of last exam _____ Date of last dental cleaning _____

What was done at your last visit? _____

Name of previous office _____

Reason for leaving that office? _____

How often do you get dental examinations? _____

How often do you floss? _____ Do you use a waterpik? _____ Sonicare? _____

Do you have any dental concerns? If you please describe: _____

Are any of your teeth:

Sensitive to hot or cold? Yes No Sensitive to sweets? Yes No

Sensitive when biting/chewing? Yes No

Have you notice any mouth odors or bad tastes? Yes No

Do you frequently get any cold sores, blisters or any other oral lesions? Yes No

If so, where? _____

Do your gums bleed or hurt? Yes No

Have you notice any loose teeth or change in your bite? Yes No

Does food tend to get caught between your teeth? Yes No, if so, Where? _____

Do you:

Clench or grind your teeth awake or asleep? Yes No

Mouth breathe while you are awake or asleep? Yes No

Have tired jaws in the morning? Yes No

Smoke / Chew tobacco? Yes No

Have you ever had:

Orthodontic treatment? Yes No Oral surgery? Yes No

Periodontal treatment? Yes No Mouth guard? Yes No

Serious mouth or neck injury? Yes No

If so, please describe _____

Clicking or popping of the jaw? Yes No Difficulty opening or closing? Yes No

Head aches or shoulder aches? Yes No

Do you feel nervous about having dental treatment? _____

If so, what is your biggest concerns _____

Have you ever had an upsetting dental experience? Yes No

If so, Please described? _____

Is there anything else you would like us to know please describe: _____



Importance of prophylactic antibiotics after breast implantation

The breast implants are a prosthetic device, and considered medically in the same or similar category as an artificial knee, hip or heart valve. As such there is a small lifetime risk of infection. Therefore, it is necessary to be very careful with anything that might seed the blood stream with bacteria that can occur after dental visits, it is important that if you are undergoing any procedure that might potentially seed your blood stream with bacteria that you take prophylactic antibiotics. It is also important that you notify your health care provider that you have breast implants.

ONLY SIGN IF YOU HAVE HAD BREAST IMPLANTS

Name of patient _____ Date _____

Dr. Name: _____

Phone number: _____

Date implants were done: _____

I _____, refuse to premedicate with antibiotics.

Signature

Date

For office use only:

Any comments from plastic surgeons office:



FINANCIAL POLICY

We would like to thank you for choosing us as your dental care provider. Our goal is to ensure that, as our patient and our guest, you receive the best treatment and service from Rainbow Dental Care.

As part of our commitment to serving you better, we have drafted this document (financial policy), which we would like you to read and then sign. The information below explains how we can help you with any financial need that you may have as a result of treatments that we offer. It also clarifies the responsibilities of both you and Rainbow Dental Care with respect to payment for any work that we carry out or any appointment that we may book for you. We would also ask you to pay special attention to our policy regarding canceling an appointment.

Policy:

PAYMENT IS DUE IN FULL AT THE TIME OF TREATMENT UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE.

RAINBOW DENTAL CARE RESERVES THE RIGHT TO CHARGE ANY PATIENT (i.e. YOU) A CANCELLATION FEE OF \$50 PER HOUR OF YOUR APPOINTMENT FOR MISSING AN APPOINTMENT WITHOUT GIVING a 24HRS NOTICE. IF YOUR APPOINTMENT IS SCHEDULED FOR MONDAY THEN YOU MUST CALL NO LATER THAN 10AM ON FRIDAY MORNING PRECEEDING YOUR APPOINTMENT TO CANCEL OR YOU WILL BE CHARGED A FEE.

IF YOUR APPOINTMENT IS ON A SATURDAY AND YOU DO NOT CALL 24 HOURS BEFORE YOUR APPOINTMENT TO CANCEL THEN YOU WILL BE CHARGED \$100 PER HOUR OF YOUR MISSED APPOINTMENT. TO BE ENTITLED TO ANOTHER SATURDAY APPOINTMENT YOU MUST CANCEL 48 HOURS IN ADVANCE.

Payment Options:

We accept cash, personal checks and we accept ATM/Debit cards: Mastercard, Visa, Discover, American Express. There are also Payment Plans available at competitive rates. Please ask the front desk for more details.

If for any reason a credit card payment refund is requested then the refund will be credited to the original card less a 5% administrative fee.

Insurance:

Rainbow Dental Care is a provider for a number of insurance companies but, can accept most insurance for patients. There are very few that we are unable to take. It is important to know that the insurance is a tool for you to use to help aid in getting your treatment done. It should not be relied upon. There are co-pays associated with most insurance and those co-pays are the patient's responsibility. These co-pays which is the patient portion mandated by your insurance company by Law cannot be waived however, we can assist you in other ways to get your dental treatment completed.



FINANCIAL POLICY

As a courtesy, we will bill your insurance company for covered charges. In order to bill your insurance you will need to provide us with the necessary accurate and complete information.

Remember that your insurance policy is a contract between you and your insurance company and you are responsible for all charges incurred. We accept insurance payment within 45 days from the date of service. If your insurance provider has not paid us within this period of time, and the account becomes 60 days old, the account may become a cash account and may be due and payable at that time. We are limited in knowing what the insurance will do when they send the final payment for your dental treatment and the quote we give you can only be an estimate for that reason. We try very hard to quote you the right information but, as it says on your insurance recording these only estimates not GUARENTEES.

By signing this form you confirm that:

If there is no insurance coverage available, I understand that I am responsible for all charges incurred, at the time of service.

I understand that regardless of any dental insurance coverage I may have. I am responsible for payment of dental fees, I agree to pay attorney's fees, collection fees, or court costs that may be incurred to satisfy this obligation.

In order to be fair to staff and other patients at Rainbow Dental Care, I will endeavor to keep all my appointments and understand that by not giving a 24-hour notice of cancellation I will be charged a \$50 fee per hour and if it is on a Saturday then I understand I will be charged \$100 per hour and no other appointment for a Saturday will be provided to me.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

Signature _____ Date _____



HIPAA CONSENT FORM

DATE _____

I authorize Rainbow Dental Care to use and disclose the health and medical information of _____ for the purposes of Treatment, Payment and Health Care.

*Treatment (includes activities performed by a health care provider, nurse, office staff, and other and other types of health care professionals providing care to you, coordinating or managing your care with third parties, and consultations with and between other health care providers. This consent includes treatment provided by any physician who covers my/our practice telephone as the on-call physician).

*Payment (includes activities involved in determining you eligibility for health plan coverage, billing and receiving payment for you health benefit claims, and utilization management activities which may include review of health care services for medical necessity, justification of charges, pre-certification and pre-authorization).

*Health Care Operations (includes the necessary administrative and business functions of our office).

You may review Rainbow Dental Care's "Notice of Privacy Practices" for additional information about the uses and disclosures of information described in this Consent prior to signing this Consent. Please verify that you have received a copy of our Notice by placing your initials here: _____

Because we have reserved the right to change our privacy practices in accordance with the law, the terms contained in the Notice may change also. A summary of the Notice will be posted in our office indicating the effective date of the Notice in the upper right hand corner. We will offer you a copy of the Notice on your first visit to us after the effective date of the then current Notice. We may also provide you with a copy of the Notice upon your request.

As more fully explained in the Notice, you have the right to request restrictions on how we use and disclose your protected health information for treatment, payment and health care operations purposes. We are not required to agree to your request. If we do agree, we are required to comply with your request unless the information is needed to provide you emergency treatment. Other physicians who provide call coverage for our office are required to use and disclose your protected health information consistent with the Notice.

I authorize Rainbow Dental Care to text messages and or leave messages on numbers I have provided - Also to fax information to Specialist and or patient Insurance Companies. Please verify by placing your initials here: _____

I understand that I have the right to revoke this Consent, provided that I do so in writing except to the extent that Rainbow Dental Care has already used or disclosed the information in reliance on this Consent.

Signature of Patient

Date

Signature of Person Authorized by Law

If there is anyone you would like to authorize to your information please provide us with their name below.

Name of person authorized to my information

Patient's signature



Consent to Arbitration

THE UNDERSIGNED (The "Patient") hereby consents to arbitration of any dispute, claim, collection or disagreement with Gregory Po, D.D.S. DBA RAINBOW DENTAL CARE (the "Provider") according to the following terms and condition:

1. Submission of Claim to Binding Arbitration. In the event of any dispute, claim, question, or disagreement arising from or relating to the dental care and treatment of Patient by Provider, the parties hereto shall use their best efforts to settle the dispute, claim, question, or disagreement. To this effect, they shall consult and negotiate with each other in good faith and recognizing their mutual interests, attempt to reach a just and equitable solution satisfactory to both parties. If they do not reach such solution within a period of sixty (60) days, then, upon notice by either party to the other, all disputes, claims, questions, or differences shall be finally settled by binding arbitration administered in accordance with the provisions of the Commercial Arbitration Rules of the American Arbitration Association. Each party shall bear its own costs and expenses and an equal share of the arbitrators' and administrative fees of arbitration.

2. Governing Law. This Consent is subject to and shall be governed by Nevada law and, in particular, the provisions of the arbitration statutes enacted by the State of Nevada. The undersigned further consents to Clark County, State of Nevada, being the appropriate jurisdiction and venue for the arbitration which are the claims of this Consent.

3. No Waiver. This consent does not limit, impair, or waive any substantive rights or defenses of either Patient or Provider, including the statute of limitations, nor does this consent limit, impair, or waive the procedural rights of either Patient or Provider to be heard, to present material evidence, to cross-examine witnesses, and to be represented by an attorney.

4. Miscellaneous. This consent is not a condition to the rendering of services by Provider. This consent was executed by Patient at the inception of or during the term of provision of services by provider.

Acknowledgement

THE UNDERSIGNED ACKNOWLEDGES THAT THE TERMS OF THIS CONSENT WERE EXPLAINED BY AN AGENT OF PROVIDER AND THAT PATIENT HAD FULL AND FAIR OPPORTUNITY TO SEEK CLARIFICATION AND INTERPRETATION OF THIS CONSENT.

Dated this ____ day of _____, 20____

Patient Signature

Date of Birth

Patient name (print)