Dental Care Rainbow

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: _____

Dental Care Rainbow

MEDICAL HISTORY

Patient Name: _____

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 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 _____
Have you ever taken Fosamax, Boniva, Actonel or any other medication containing Bisphosphonates? ❍ 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 ❑ Sulfa Drugs ❑ 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 ❍Yes ❍No	Cortisone Medicine ❍Yes ❍No	Hemophilia ❍Yes ❍No	Radiation Treatments ❍Yes ❍No
Alzheimer's Disease ❍Yes ❍No	Diabetes ❍Yes ❍No	Hepatitis A ❍Yes ❍No	Recent Weight Loss ❍Yes ❍No
Anaphylaxis ❍Yes ❍No	Drug Addiction ❍Yes ❍No	Hepatitis B or C ❍Yes ❍No	Renal Dialysis ❍Yes ❍No
Anemia ❍Yes ❍No	Easily Winded ❍Yes ❍No	Herpes ❍Yes ❍No	Rheumatic Fever ❍Yes ❍No
Angina ❍Yes ❍No	Emphysema ❍Yes ❍No	High Blood Pressure ❍Yes ❍No	Rheumatism ❍Yes ❍No
Arthritis/Gout ❍Yes ❍No	Epilepsy or Seizure ❍Yes ❍No	High Cholesterol ❍Yes ❍No	Scarlet Fever ❍Yes ❍No
Artificial Heart Valve ❍Yes ❍No	Excessive Bleeding ❍Yes ❍No	Hives or Rash ❍Yes ❍No	Shingles ❍Yes ❍No
Artificial Joint ❍Yes ❍No	Excessive Thirst ❍Yes ❍No	Hypoglycemia ❍Yes ❍No	Sickle Cell Disease ❍Yes ❍No
Asthma ❍Yes ❍No	Fainting Spells/Dizziness ❍Yes ❍No	Irregular Heartbeat ❍Yes ❍No	Sinus Trouble ❍Yes ❍No
Blood Disease ❍Yes ❍No	Frequent Cough ❍Yes ❍No	Kidney Problems ❍Yes ❍No	Spinal Bifida ❍Yes ❍No
Blood Transfusion ❍Yes ❍No	Frequent Diarrhea ❍Yes ❍No	Leukemia ❍Yes ❍No	Stomach/Intestinal Disease ❍Yes ❍No
Breathing Problem ❍Yes ❍No	Frequent Headaches ❍Yes ❍No	Liver Disease ❍Yes ❍No	Stroke ❍Yes ❍No
Bruise Easily ❍Yes ❍No	COVID ❍Yes ❍No	Low Blood Pressure ❍Yes ❍No	Swelling of Limbs ❍Yes ❍No
Cancer ❍Yes ❍No	Glaucoma ❍Yes ❍No	Lung Disease ❍Yes ❍No	Thyroid Disease ❍Yes ❍No
Chemotherapy ❍Yes ❍No	Hay Fever ❍Yes ❍No	Mitral Valve Prolapse ❍Yes ❍No	Tonsillitis ❍Yes ❍No
Chest Pains ❍Yes ❍No	Heart Attack/Failure ❍Yes ❍No	Osteoporosis ❍Yes ❍No	Tuberculosis ❍Yes ❍No
Cold Sores/Fever Blisters ❍Yes ❍No	Heart Murmur ❍Yes ❍No	Pain in Jaw Joints ❍Yes ❍No	Tumors or Growths ❍Yes ❍No
Congenital Heart Disorder ❍Yes ❍No	Heart Pace Maker ❍Yes ❍No	Parathyroid Disease ❍Yes ❍No	Ulcers ❍Yes ❍No
Convulsions ❍Yes ❍No	Heart Trouble/Disease ❍Yes ❍No	Psychiatric Care ❍Yes ❍No	Venereal Disease ❍Yes ❍No
			Yellow Jaundice ❍Yes ❍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 _____

Dental Care Rainbow

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. _____	_____

Rainbow Dental Care

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 noticed 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: _____

_____

Dental Care Rainbow

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.

Rainbow Dental Care

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 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 your eligibility for health plan coverage, billing and receiving payment for your 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 if 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)