Alex D. Blazzard, DDS

840 Pinnacle Court, Ste 6A
Mesquite, NV 89027
702.345.8686 p
702.345.8680 f
www.BlazzardDDS.com

PATIENT REGISTRATION

First Name: ______________________ Last Name: ______________________ Middle Initial: _____
Preferred Name: ______________________

Responsible Party (if someone other than the patient)

First Name: ______________________ Last Name: ______________________ Middle Initial: _____
Mailing Address: ______________________ Street Address: ______________________
City, State, Zip: ______________________ City, State, Zip: ______________________
Home Phone: ______________ Work Phone: ______________ Cell Phone: ______________
Birth Date: ______________ Social Security #: ______________ Drivers Lic. # & State: ____________
□ Responsible Party is also Policy Holder □ Primary Insurance Policy Holder □ Secondary Insurance Policy Holder

Patient Information

Mailing Address: ______________________ Street Address: ______________________
City, State, Zip: ______________________ City, State, Zip: ______________________
Home Phone: ______________ Work Phone: ______________ Cell Phone: ______________
Birth Date: ______________ Social Security #: ______________ Drivers Lic. # & State: ____________
□ Patient is also Policy Holder □ Primary Insurance Policy Holder □ Secondary Insurance Policy Holder
Sex: □ Male □ Female Marital Status: □ Married □ Single □ Divorced □ Separated □ Widowed
Email: ______________________ □ I would like to receive correspondences via e-mail.
Employment Status: □ Full Time □ Part Time □ Retired Employer: ______________ Occupation: ______________
Student Status: □ Full Time □ Part Time
Preferred Pharmacy: ______________ Reason For Visit: ______________ Referred By: ______________
Emergency Contact: ______________ Emergency Contact #: ______________

Primary Insurance Information

Name of Insured: ______________________ Relationship to Patient: □ Self □ Spouse □ Child □ Other
Insured Social Security #: ______________________ Insured Birth Date: ______________________
Employer: ______________________ Insurance Company: ______________________
Mailing Address: ______________________ Mailing Address: ______________________
City, State, Zip: ______________________ City, State, Zip: ______________________
Remaining Benefits: ______ Remaining Deductible: _____ Phone Number: ______________________

Secondary Insurance Information

Name of Insured: ______________________ Relationship to Patient: □ Self □ Spouse □ Child □ Other
Insured Social Security #: ______________________ Insured Birth Date: ______________________
Employer: ______________________ Insurance Company: ______________________
Mailing Address: ______________________ Mailing Address: ______________________
City, State, Zip: ______________________ City, State, Zip: ______________________
Remaining Benefits: ______ Remaining Deductible: _____ Phone Number: ______________________

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MEDICAL HISTORY

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.

		If yes, please explain:
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 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? □ Nursing?
□ Taking oral contraceptives?

Are you allergic to any of the following?
□ Aspirin □ Penicillin □ Codeine □ Acrylic □ Metal □ Latex □ Local Anesthetics
□ Other If yes, please explain: ______

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

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

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 status.

Patient/Guardian Signature: ______ Print Patient Name: ______ Date: ______

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PAYMENT OPTIONS

Thank you for choosing us for your dental needs. Our goal is to provide you with optimal care based on your individual needs. To assist you in receiving this care, we offer several payment options. You can choose to pay by cash, check or major credit card and we also offer NO Interest Payment Plans through CareCredit. Thank you for reviewing below, your payment options offered at our office:

□ Cash, Check, Visa, MasterCard, Discover or American Express

□ 50% at time of reservation and 50% at time of service

□ Low monthly payments through CareCredit, a financial institution (upon credit approval)

□ 5% RSVP Courtesy Adjustment for estimated patient balance over $300 prepaid in full upon scheduling your appointment

When estimating insurance coverage, we must also stress the word *estimate* as dental benefits are determined by each patient's dental contract. Every patient's dental plan is different, and necessary dental services are not necessarily covered. Most dental plans are designed to *assist* patients with the dental expense. Very few dental plans fully cover all dental services. If you bring in a copy of your dental plan, our staff will be happy to help you interpret your dental benefits. Without a copy of your dental benefit plan, only an estimate can be provided based on what a "typical" dental plan provides. The patient portion of the fees including co-payments and deductibles, are due at the time service is rendered. If your dental plan pays more than expected, your account will indicate a credit. If your dental plan pays less than expected, a balance due will be reflected on your monthly statement. If your dental plan later determines that you were not eligible for coverage, the balance becomes your responsibility. Please inform our office prior to any change in insurance. Fee estimates for future treatment are guaranteed for six months from the date of the original examination.

I authorize payment directly to this office of all insurance benefits otherwise payable to me for the services rendered.
I authorize this office and/or any provider or supplier in this office to release patient information required to secure the payment of benefits to any necessary party including my insurance company. I authorize use of this signature on all insurance submissions.

I understand that any insurance estimate given by this office is not a guarantee of actual insurance payment or coverage. I also understand that I am responsible for all charges incurred for dentistry performed upon me and my dependents. Any insurance claim not paid in full after 60 days will become my responsibility at that time. I further understand a service charge of 1.5% per month on any unpaid balance will be charged on all accounts exceeding 60 days. Accounts with outstanding balances after 90 days will be submitted to a collection agency. The patient is responsible for any fees associated with this action. Failure to keep a scheduled appointment prevents other patients from being seen by the dentist. A $25.00 fee will be charged for failed appointments when 24-hour notice is not given. A $25.00 fee will also be charged for any returned checks.

Patient/Guardian Signature: ______________________________ Print Patient Name: __________________________ Date: ___________

We are available any time to assist you. Please contact us with any questions.
We want you to *SMILE MORE*, and think about it less.

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office contact person – Heather

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Effective date of notice: 06/01/05

In the course of your care as a patient, we may use or disclose personal and health related information about you in the following ways:

- Your personal health information, including your clinical records, may be disclosed to another healthcare provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.
- Your healthcare records, as well as your billing records, may be disclosed to another party, such as an insurance carrier, an HMO, PPO or your employer (if they are responsible for the payment of your services).
- Your name, address, phone number and healthcare records may be used to contact you regarding appointment reminders or to provide information about treatment alternatives that may be of interest to you. If you are not at home to receive an appointment reminder, a message may be left on your answering machine.

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in the following circumstances:

- If we are providing healthcare services to you based on the orders of another healthcare provider.
- If we provide healthcare services to you in an emergency.
- If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
- If there are substantial barriers to communication with you, but in our professional judgment we believe that you intend for us to provide care.
- If we are ordered by the court or another appropriate agency.

Any use or disclosure of your protected health information other than as described in the outline above will only be made upon your written authorization.

We normally provide information about your healthcare to you in person at the time you receive dental care from us. We may also mail information to you regarding your healthcare, appointment reminders or about the status of your account. If you would like to receive this information at an address other than your home or if you would like this information in a different form, please advise us in writing as to your preferences.

You have the right to inspect and or copy your health information for seven years from the date that the record was created or for as long as the information remains in our files. In addition, you have the right to request an addendum to your health information. Requests to inspect, copy or amend your health related information should be provided in writing.

We are required by state and federal law to maintain the privacy of your patient file and the protected health information contained in your file. We are further required by law to abide to the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice, we will notify you in writing as soon as possible following the changes. Any change in our privacy notice will apply to all of your health information in our files.

You may review this offices “Notice of Privacy Practices” for additional information about the uses and disclosures of information described in this Authorization prior to signing this Authorization.

I have read and understand this form. I am signing it voluntarily. I authorize the disclosure of my health information as described in this form.

Patient/Guardian Signature: ______________________________ Print Patient Name: ______________________________ Date: __________