PATIENT INFORMATION

(This information is necessary for our files and will be considered CONFIDENTIAL)

Date ______________________ Age ______ Birthday ____________________ ☐ Male ☐ Female

Patient's Name ______________________________ Nickname ____________________
LAST FIRST INITIAL

If patient is a minor, give name of parent or legal guardian ____________________ Relationship ____________________

Residence Address ______________________________ For how long? __________ ☐ own ☐ rent
STREET CITY ZIP

Patient is: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ Minor Cell Phone ( ) ____________

Driver's License No. ____________________ Social Security No. ____________________ Res. Phone ( ) ____________

Employed by ____________________ How long? ____________________ Occupation ____________________

Business Address ______________________________ Bus. Phone ( ) ____________
STREET CITY ZIP

Spouse's Name ____________________ Driver's License No. ____________________ Soc. Sec. No. ____________________

Employed by ____________________ How long? ____________________ Occupation ____________________

Business Address ______________________________ Bus. Phone ( ) ____________
STREET CITY ZIP

Emergency contact: ____________________ Phone Numbers: ____________________ Relationship ____________________

Complete Address ______________________________ Res. Phone ( ) ____________
STREET CITY ZIP ☐ **I HAVE NO PHYSICIAN**

Name of Physician ______________________________ ( ) ____________
ADDRESS CITY TELEPHONE

Former Dentist ______________________________ ( ) ____________
ADDRESS CITY TELEPHONE

Why are you changing dentists? ______________________________

Purpose of appointment ______________________________

Is this office for Emergency Dental Care? ☐ Yes ☐ No If yes, explain ______________________________

Whom may we thank for referring you? ______________________________

FINANCIAL INFORMATION

Person responsible for this account ______________________________ Relationship ____________ ( ) ____________
TELEPHONE

Address ______________________________ ( ) ____________
STREET CITY ZIP CELL PHONE

Name of insurance company (**primary insurance**) ______________________________ ( ) ____________
TELEPHONE

____
INSURED PERSON'S NAME BIRTHDATE RELATIONSHIP SOCIAL SECURITY NO.

____
NAME OF EMPLOYER GROUP NO. ID NO.

Name of insurance company (**secondary insurance**) ______________________________ ( ) ____________
TELEPHONE

____
INSURED PERSON'S NAME BIRTHDATE RELATIONSHIP SOCIAL SECURITY NO.

____
NAME OF EMPLOYER GROUP NO. ID NO.

TERMS & CONDITIONS

As a condition of treatment by this office, I understand financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental service performed without prior financial arrangements, must be paid for in cash at the time services are performed.

I understand that dental services furnished to me are charged directly to me and that I am personally responsible for payment of all dental services. If I carry insurance, I understand that this office will help prepare my insurance forms to assist in making collections from insurance companies and will credit such collections to my account. However, this dental office cannot render services on the assumption that charges will be paid by an insurance company.

Assignment of Insurance: I hereby authorize my insurance company to pay directly to my dentist benefits accruing to me under my policy.
A service charge of 1 ½% per month (18% per annum) (but in no event more than the maximum rate permissible under state law) will be charged on the unpaid principal balance on all accounts not paid within 60 days of treatment date.

I understand that the fee estimate listed for this dental case can only be extended for a period of three months from the date of the treatment estimate.

In consideration of the professional services rendered to me, or at my request, by the Doctor and/or his staff, I agree to pay, therefore, the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be billed unless objected to by me, in writing, within the time for payment thereof. Additionally, I agree that a waiver for any breach of any term or condition hereunder shall not constitute a waiver of any further term or condition. I agree that in the event that either this office or I institute any legal proceedings with respect to amounts owed by me for services rendered, the prevailing party in such proceedings shall be entitled to recover all costs incurred including reasonable attorney's and/or collection fees.

I grant my permission to you, or your assigns, to telephone me at home or at my work to discuss matters related to this form, treatment and financial matters.

I have read the above conditions of treatment and agree to their content:

SIGNED ______________________________ Date ____________________

HEALTH QUESTIONNAIRE

These questions are for your benefit and assure that treatment will take into consideration your past and present health status. Some questions may seem unrelated to your dental condition, but they are all associated with proper oral health care.

Please answer each question. Circle or check the appropriate answers.

MEDICAL HISTORY

1. Are you in good health? .... Yes No
2. Date of last physical examination ____________
3. Are you now under the care of a physician? .... Yes No
   If so, what is the condition being treated? ____________
4. Have you ever had any serious illness or operation? .... Yes No
   If so, what illness or operation? ____________
5. Have you ever been hospitalized? .... Yes No
   If so, what was the problem? ____________
6. Are you taking any ☐ medications, ☐ drugs or ☐ herbs? .... Yes No
   If so what and dosage ____________
7. Are you using any recreational drugs (marijuana, cocaine, etc.)? ☐ Yes ☐ No If so, what? ____________
8. Have you ever been premedicated with antibiotics for your dental treatment? .... Yes No
9. Are you sensitive or allergic to any drugs or materials? ☐ Penicillin ☐ Tetracycline ☐ Sulfa Drugs ☐ Aspirin ☐ Codeine ☐ Latex ☐ Other
   If other, what drugs or materials? ____________
10. Do you have or have you had any of the following: (Please circle "Y" for Yes or "N" for No – answer all conditions):

Y N Anemia	Y N Hay Fever	Y N Head Injuries	Y N Cerebral Palsy	Y N Rheumatic Fever	Y N Sickle Cell Disease	Y N Psychiatric Treatment
Y N Herpes	Y N Glaucoma	Y N Heart Failure	Y N Drug Addiction	Y N Tuberculosis (T.B.)	Y N Cortisone Medicine	Y N Hepatitis or Jaundice
Y N Stroke	Y N Tonsillitis	Y N Scarlet Fever	Y N Kidney Disease	Y N Blood Transfusion	Y N Allergies to Metals	Y N Difficulty Swallowing
Y N Ulcers	Y N Hemophilia	Y N Sinus Trouble	Y N Chemotherapy	Y N Joint Replacement	Y N Excessive Bleeding	Y N Congenital Heart Lesions
Y N Diabetes	Y N Cold Sores	Y N Heart Murmur	Y N Stomach Ulcers	Y N Nervous Disorders	Y N Mitral Valve Prolapse	Y N X-ray or Cobalt Treatment
Y N Arthritis	Y N Emphysema	Y N Liver Disease	Y N Angina Pectoris	Y N Tumors/Growths	Y N High Blood Pressure	Y N Radiation Treatment of any kin
Y N Asthma	Y N Rheumatism	Y N Blood Disease	Y N Mental Disorder	Y N Allergies Or Hives	Y N HIV Related Complex	Y N Venereal Disease (Syphilis, Gonorrhea)
Y N Cancer	Y N Chicken Pox	Y N Heart Ailments	Y N Thyroid Disease	Y N Pain in Jaw Joints	Y N Respiratory Disease	Y N Acquired Immune Deficiency Syndrome
Y N Seizures	Y N Bruise Easily	Y N Heart Attack	Y N Fainting Spells	Y N Artificial Prosthesis	Y N Epilepsy or Seizures	Y N TMJ (Temporomandibular Joint) Disorder

11. Do you have any disease, condition or problem not listed that you think we should know about? .... Yes No
    If so, what? ____________
12. Do you wear a cardiac pacemaker, or have you had heart surgery? .... Yes No
13. Do you smoke? If yes, how much? _______ ☐ Cigarettes ☐ Cigars ☐ Packs ___ per day .... Yes No
14. Have you ever taken the drugs ☐ Phen-Phen, ☐ Redux or any ☐ diet drugs **OR** ☐ Bisphosphonate for osteoporosis? .... Yes No
15. (Women) Are you pregnant? If so, how many months? __________ .... Yes No
16. (Women) Do you have any problems associated with your menstrual period? .... Yes No
17. (Women) Do you take any birth control medication or hormones? .... Yes No

Are you currently being treated for or have a history of the follow? (Please circle answer)

Chronic Cough (3 or more weeks)	Yes	No	When? ________	Recent Travel Out of U.S.	Yes No	When? ________
Bloody Mucus/Spit	Yes	No	When? ________	Unexplained Weight Loss	Yes No	When? ________
Night Sweats	Yes	No	When? ________	Live in Concentrated Housing	Yes No	When? ________
Been Exposed to Tuberculosis	Yes	No	When? ________			

DENTAL HISTORY

1. Have you ever had a local anesthetic (Novocaine, etc.)? .... Yes No
2. Have you ever had any unfavorable reaction from a local anesthetic? .... Yes No
3. Have you had any serious trouble associated with any previous dental treatment? .... Yes No
   If so, explain? ____________
4. How long since your last full mouth x-rays? _____ weeks _____ months _____ years
5. How long since your last dental treatment? _____ weeks _____ months _____ years
6. Does dental treatment make you nervous? ☐ slightly ☐moderately ☐ extremely? .... Yes No
7. Would you desire to be pre-sedated? .... Yes No

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health or if my medications change, I will, without fail, inform the doctor at my next appointment.

Reviewed by ______________ Lic. # ________ Date ___________

PATIENT NAME: ______________ **SIGNATURE**: ______________ DATE ______________

CONSENT FOR TREATMENT: I hereby grant authority to the dentist(s) in charge of the care of the patient whose name appears of this Health History form, to administer such anesthetics, analgesics, sedatives, nitrous oxide sedation and intravenous sedation; and to perform such operations as may be deemed necessary or advisable in the diagnosis an treatment of this patient. I have been informed of all possible complication of the procedures, anesthetics and/or drugs.

All services are rendered and accepted under the terms and conditions printed on the reverse hereof:
Authorization must be signed by the patient, or by the nearest relative in the case of a minor or when the patient is physically or mentally incompetent.

SIGNED: ______________ Date: ______________ Relationship to Patient ______________

BRIAN R. KARN, D.M.D.

CONSENT FOR USE AND DISCLOSURE OF HEALTH & PERSONAL INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: ____

Address: ____

Telephone: ______________________ E-mail: ______________________

Patient Number: ______________________ Social Security Number: ______________________

SECTION B: TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations. You are also providing your consent for the release of any personal information to carry out treatment, payment activities, healthcare operations, referring providers and/or their representatives and pharmacists and/or their representatives.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting our office at 851 S. Rampart Boulevard, Suite 230, Las Vegas, Nevada, 89145, our telephone number is (702) 341-9160 or e-mail us as drkarn@drkarn.com.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, ______________________________, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and heath care operations.

Signature: ______________________________ Date: ______________________

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: ____

Relationship to Patient: ____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include completed Consent in the patient's chart.

REVOCATION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will *not* affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: ______________________________ Date: ______________________