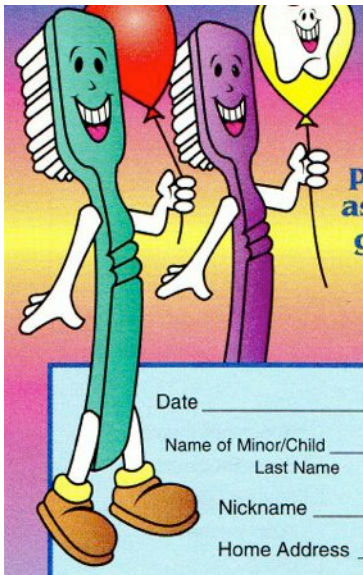
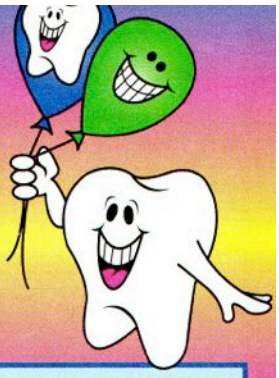


Welcome!

We are pleased to welcome you and your child to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your child's dental health.



PATIENT INFORMATION

Date _____ SS/HIC/Patient ID # _____ Birthdate _____

Name of Minor/Child _____ Sex ☐ M ☐ F Age _____
Last Name First Name Middle Initial

Nickname _____ Hobbies _____ Cell Phone (____) _____

Home Address _____
Street City State Zip

Mailing Address _____
Street City State Zip

School Name _____ School Phone (____) _____

Person financially responsible _____ Home Phone (____) _____ Work Phone (____) _____

Whom may we thank for referring you? _____

INSURANCE

Father's/Guardian's Name _____

Address (if different from patient's) _____

Home Phone (____) _____ Work Phone (____) _____
(if different from above) (if different from above)

E-mail _____

Employer _____

Soc. Sec. # _____ Birthdate _____

Do you have dental insurance coverage for minor/child? ☐ Yes ☐ No

Plan Name _____ Phone (____) _____

Address _____

Group # _____ Policy # _____

Mother's/Guardian's Name _____

Address (if different from patient's) _____

Home Phone (____) _____ Work Phone (____) _____
(if different from above) (if different from above)

E-mail _____

Employer _____

Soc. Sec. # _____ Birthdate _____

Do you have dental insurance coverage for minor/child? ☐ Yes ☐ No

Plan Name _____ Phone (____) _____

Address _____

Group # _____ Policy # _____

Is your child eligible for treatment under Medical Assistance? ☐ Yes ☐ No Child's Medical Assistance I.D. # _____

DENTAL HISTORY

Date of last visit to a dentist _____ For what service? _____

	YES	NO		YES	NO
Has child complained about dental problems?	☐	☐	Is fluoride taken in any form?	☐	☐
Does child brush teeth daily?	☐	☐	Any injuries to mouth, teeth, head?	☐	☐
Does child use floss every day?	☐	☐	Any unhappy dental experiences?	☐	☐

Any mouth habits - thumbsucking, nail biting, mouth breathing, pacifier, sleeping with bottle, etc? ☐ ☐

Please Complete Both Sides

MEDICAL HISTORY

Minor/Child's Physician _____ City/State _____ Phone (____) _____

Date of last physical examination _____ Results _____

	YES	NO	
Is Minor/Child under care of physician now?	☐	☐	Medications _____
Receiving any medication or drugs?	☐	☐	_____
Ever been hospitalized?	☐	☐	_____
Ever had surgery?	☐	☐	Allergies _____
Is there excessive bleeding when cut?	☐	☐	_____

Has minor/child had any history of or difficulty with any of the following? If yes, please check (✔).

☐ A.I.D.S./H.I.V.	☐ Cerebral Palsy	☐ Epilepsy	☐ Kidney Disease	☐ Rheumatic Fever
☐ Anemia	☐ Chicken Pox	☐ Fainting	☐ Liver Disease	☐ Sinus Problems
☐ Asthma	☐ Convulsions	☐ Hearing Problems	☐ Measles	☐ Thyroid Disease
☐ Bladder Problems	☐ Diabetes	☐ Heart Problems	☐ Mononucleosis	☐ Tuberculosis
☐ Cancer	☐ Drug/Alcohol Abuse	☐ Hepatitis	☐ Mumps	☐ Other

EMERGENCY CONTACT

In the event of an emergency, whom should we contact?

Name _____ Relationship _____ Phone (____) _____

Name _____ Relationship _____ Phone (____) _____

AUTHORIZATIONS

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if my minor child ever has a change in health.

Minor/Child Consent

I am the parent, guardian, or personal representative of _____
Please Print Name of Minor/Child

and there are no court orders now in effect that prohibit me from signing this consent. I do hereby request and authorize the dental staff to perform necessary dental services for the child named above, including but not limited to x-rays, and administration of anesthetics, which are deemed advisable by the doctor, whether or not I am present when the treatment is rendered.

Insurance Assignment and Release

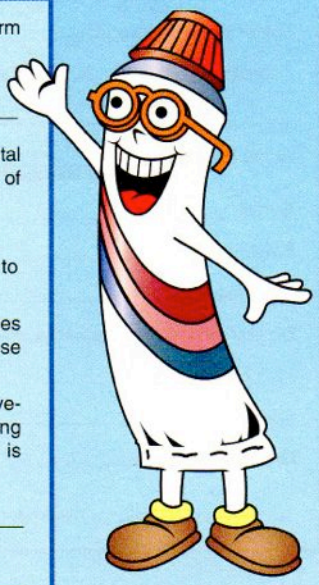
I certify that my dependent(s) is covered by insurance with _____ and assign directly to
Name of Insurance Company(ies)

Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my minor/child's health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when the current treatment plan is completed or one year from the date signed below.

_____ _____
Signature of Parent, Guardian or Personal Representative — Date

_____ _____
Please print name of Parent, Guardian or Personal Representative — Relationship to Patient



UPDATE

TO BE COMPLETED AT LATER VISIT

Has there been any change in patient's health since last dental appointment? ☐ Yes ☐ No

If yes, please describe _____

Is patient taking any new medications? ☐ Yes ☐ No If yes, please list _____

Date _____ Parent/Guardian Signature _____

Date _____ Dentist Signature _____

Desert Smiles

Sam Partovi, D.M.D.
10175 W. Twain Ave. Suite 120
Las Vegas, NV 89147
(702) 202-2300

We would like to thank you for choosing Desert Smiles as your dental care provider. Our goal is to ensure that, as our patient and our guest, you will receive the best treatment and services from Desert Smiles.

Our office philosophy has always been to keep the needs of our patients as our number one priority. In keeping with this philosophy, it is essential that we receive 48 hours (2working days) notice if you cannot keep your reserved appointment so we can accommodate those waiting for the next available appointment. Our protocol for reserving an EXTENDED APPOINTMENT is to collect a non-refundable deposit of 50% of the patient responsibility portion of the treatment scheduled. You may pay this by cash, money order, debit card and or credit card. Your time is as valuable as ours. We thank you in advance for this courtesy.

Desert Smiles reserves to charge any patient a cancellation fee of $50.00 per reserved hour for missing an appointment and or without giving a 48 hours (2 working days) notice prior to cancelling.

NON-INSURED PATIENTS
If you have no insurance, our office policy requires 100% of the total fee's due at the start of your appointment the day services are rendered. There is *no payment plan option* for Desert Smiles.

INSURED PATIENTS
Insurance is a vehicle that only assists you with covering the cost of the dental care which is provided to you. It is a contract between you and the insurance company, as a courtesy to our patients with dental coverage; we will gladly accept your insurance as partial payment and are happy to assist you in the processing of these claims.

Unfortunately, there is no contract agreement between Desert Smiles and your insurance carrier; therefore, in the event that your insurance carrier does not pay within the sixty (60) days of the claims submission, the balance responsibility for all fees incurred at Desert Smiles reverts back to the responsible party for this account.

Our office policy requires that the patient pay their percentage of the bill at the time service is rendered. The percentage that you will have to pay depends on your insurance carrier.

I hereby agree to be the responsible party for the cost of any cancellation fee's or treatment fees that may incur on this account. I authorize/consent Desert Smiles to take Dental Radiographs. I have read the above statement and agree to the policy and terms for the office of Desert Smiles.

SIGNATURE OF PATIENT / GUARANTOR **DATE**

***Should payment exceed sixty (60) days from original billing date, there may be a finance charge and or interest accrued at the state allowed rate.**

HIPAA CONSENT FORM

DATE_____

I authorize Desert Smiles 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, coordination or managing your care with third parties, and consultations with and between other health care providers. This consent includes treatment provided by any physicians 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 Operation (includes the necessary administrative and business functions of our office).

You may review Desert Smiles "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 indication the effective date of 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 understand that I have the right to revoke this Consent, Provided that I do so in writing except to the extent that Desert Smiles has already used or disclosed the information in reliance on this Consent.

Signature of Patient

Date