Allay Dental

We care about your fillings

Thank you for trusting us with your dental care

We promise to provide you with our best service. If you have any questions, please do not hesitate to let us know.

2696 W. Ann Rd. Ste. 111 | North Las Vegas, NV 89031 | 702-313-6888

Whom may we thank for referring you? _____

PATIENT INFORMATION

Name _____ Preferred Name _____

Date of Birth ____/____/____ Sex ☐ Male ☐ Female

Social Security # ____-____-____ Driver's License _____

Home Address _____ Apt # _____

City _____ State _____ Zip _____

Home Phone (____) _____ Cell # (____) _____

E-mail _____

☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐ Other_____

Person to contact in case of emergency _____

Relationship to Patient _____ Phone (____) _____

EMPLOYER/SCHOOL INFORMATION

Employer/School _____ Phone (____) _____

Address _____

City _____ State _____ Zip _____

Spouse/Parent's Name _____ Employer _____

PRIMARY INSURANCE INFORMATION

(Please give your driver's license or state-issued ID and dental insurance card(s) to the receptionist to copy for file)

Subscriber _____ Relationship to Patient _____

Date of Birth ____/____/____ SS#/Member ID _____

Employer _____ Phone (____) _____

Insurance Company _____ Group # _____

Phone (____) _____

SECONDARY INSURANCE INFORMATION

Subscriber _____ Relationship to Patient _____

Date of Birth ____/____/____ SS#/MemberID _____

Employer _____ Phone (____) _____

Insurance Company _____ Group # _____

Phone (____) _____

MEDICAL HISTORY

Physician Name _____ Phone (_____) _____

Specialist Name _____ Phone (_____) _____

Are you currently under the care of a physician? ☐ 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

If yes, please explain: _____

Do you take, or have you taken, Phen-Fen (diet medicine) or Redux? ☐ Yes ☐No

If yes, please explain: _____

Do you take, or have you ever taken, oral or IV bisphosphonates? (Fosamax, Boniva, Reclast…) ☐ Yes ☐No

If yes, please explain: _____

Do you use controlled substances? ☐ Yes ☐No Do you use tobacco? ☐ Yes ☐No

Have you ever been told that you need to pre-medicate for appointments? ☐ Yes ☐No

Women - Are you: ☐ Pregnant/Trying to get pregnant? ☐ Nursing?

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

☐ Aspirin ☐ Codeine ☐ Dental Anesthetics ☐ Erythromycin ☐ Jewelry/Metals
☐ Latex ☐ Penicillin ☐ Tetracycline ☐ Other _____

DO YOU HAVE, OR HAVE YOU HAD, ANY OF THE FOLLOWING? (IF NONE APPLY, PLEASE INDICATE SO ON THE LAST☐ .)

☐ Abnormal Bleeding
☐ Alcohol/Drug Addiction
☐ AIDS/HIV Positive
☐ Alzheimer's Disease
☐ Anaphylaxis
☐ Anemia
☐ Angina
☐ Arthritis/Gout
☐ Artificial Heart Valve
☐ Artificial Joint
☐ Asthma
☐ Blood Disease
☐ Blood Transfusion
☐ Breathing Problem
☐ Bruise Easily
☐ Cancer _____
☐ Chemotherapy
☐ Chest Pains
☐ Cold Sore/Fever Blister
☐ Colitis
☐ Congenital Heart Disorder
☐ Convulsions
☐ Diabetes
☐ Emphysema
☐ Epilepsy/Seizures
☐ Excessive Thirst
☐ Fainting Spells/Dizziness
☐ Frequent Cough
☐ Frequent Diarrhea
☐ Frequent Headaches
☐ Genital Herpes
☐ Glaucoma
☐ Hay Fever
☐ Head/Neck Cancer
☐ Heart Attack/Failure
☐ Heart Murmur
☐ Heart Pacemaker
☐ Heart Surgery
☐ Heart Trouble/Disease
☐ Hemophilia
☐ Hepatitis A
☐ Hepatitis B or C
☐ Herpes
☐ High Blood Pressure
☐ High Cholesterol
☐ Hypoglycemia
☐ Irregular Heartbeat
☐ Kidney Problems
☐ Leukemia
☐ Liver Disease
☐ Low Blood Pressure
☐ Lung Disease
☐ Mitral Valve Prolapse
☐ Osteoporosis
☐ Pain in Jaw Joints
☐ Psychiatric Care
☐ Radiation Treatment
☐ Recent Weight Loss
☐ Rheumatic Fever
☐ Rheumatism
☐ Shingles
☐ Sickle Cell Disease
☐ Sinus Trouble
☐ Stroke
☐ Swelling of Limbs
☐ Thyroid Disease
☐ Tonsillitis
☐ Tuberculosis
☐ Tumors/Growths
☐ Ulcers
☐ Venereal Disease
☐ Other: _____
_____
_____
_____
☐ **NONE OF THE ABOVE**

"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, Parent, or Guardian Signature **Date**

_____ _____
Doctor Signature **Date**

Allay Dental

We care about your fillings

Thank you for choosing Allay Dental. Our primary mission is to deliver the best personalized care with patient education. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:

- Cash, Visa, Mastercard, Discover, or American Express
- NO INTEREST[1] Payment Plans[2] from CareCredit
  - Allows you to pay over time with NO INTEREST[1] & NO annual fees or prepayment penalties
  - Convenient, low monthly payment plans[2] also available

Please note: All fees incurred through services rendered by Allay Dental, Dr. Rachel M. Baek and all employees and/or associates are due at the time services are rendered. All estimated co-payments and deductibles, as determined by our staff, will be collected prior to treatment commencing. Any portions not covered by your insurance company are the patient/guarantors full responsibility and are due within 30 days of insurance benefit payment being received.

Please read and initial the following statements:

1) _____ The patient understands the above statement and that the patient is responsible for all fees incurred in this office.

2) _____ The patient understands that they will receive a detailed estimation of all co-payments and deductibles due at the patient's appointments. The patient understands co-payments/deductibles, as estimated by employees, are due prior to treatment commencing.

3) _____ *The patient understands that the patient's employer negotiated the patient's insurance contract, not Allay Dental or its employees. If the patient has a dispute with my insurance company the patient will inform the patient's employer.

4) _____ If the patient's coverage is terminated or the patient has not updated their insurance coverage the patient is fully responsible for all fees incurred regardless.

5) _____ Allay Dental does have a $50 fee for last-minute cancellations/reschedules. Please give us at least a 48-hour notice to avoid fee(s).

** Allay Dental is here to serve you and any dispute you do have with your insurance company, we will assist you with handling in any and every way we can. We do house an insurance specialist and she resubmits incorrectly paid claims daily. We will attempt in every way to make sure the insurance company is giving you every benefit you deserve within contractual limits*

"I authorize Allay Dental to provide my Insurance Company with any information needed to process my or my dependents claims for payments."

"I authorize my insurance company to release all benefit payments for myself or dependents to Allay Dental."

Patient, Parent, or Guardian Signature **Date**

HIPAA (Health Insurance Portability and Accountability Act of 1996):

This office is 100% HIPPA compliant and will always protect your personal information as if it's our own. We have included a brochure explaining your rights under the Health Insurance Portability and Accountability Act of 1996.
We highly recommended you call your insurance company and ask them to use an alternate ID number, other than your social security number, on all of your insurance cards. Also, if you would like someone to have the ability to discuss your treatment or account that is not on your account we must receive an authorization in writing from the account holder.

"I have received all compliance information from Allay Dental and understand Allay Dental will protect my information as if it is their own."

Patient, Parent, or Guardian Signature **Date**

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1 If paid within the promotional period. Otherwise, interest assessed from purchase date. Minimum monthly payment required.

2 Subject to credit approval

3 However, if we do not receive payment from your insurance carrier within 90 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.