Jamie Marvel, DDS
410 Fleischmann Way, Suite A.
Carson City, NV 89703
(775) 884-3322

www.marveldental.com

PATIENT INFORMATION

Name________________________________ Preferred Name__________________________
Address City_______________State________Zip_____
Birthdate______________SS#______________Email Address________________________
Cell Phone ________________ Home Phone______________ Work Phone______________
Employer (or School) Occupation(or Grade)_______________
Employer Address_______________________City______________State________Zip _____
Spouse or Parent Name___________________Employer___________Phone______________
Emergency Contact______________________Relation___________Phone______________
Sex ☐ Male ☐ Female
Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated ☐ Partnered ___ years

How did you choose our office?

- ☐ Website/online search
- ☐ Saw sign/building
- ☐ Newspaper
- ☐ Yellowpages
- ☐ Previous patient of Dr. Marvel
- ☐ Referred By ______________________________
- ☐ Referred by another doctor____________________
- ☐ Other______________________________________

INSURANCE INFORMATION

Name of Insured_______________________________ Relation to Patient______________
Birthdate______________SS#_________________ Date Employed_________________
Employer Work Phone____________________
Employer Address_______________________City______________State________Zip_____
Insurance Co. Group # ID_______________
Address City State________Zip ______
How much is your deductible? How much have you used?_________Max Annual Benefit_________

SECONDARY INSURANCE INFORMATION

Name of Insured_______________________________ Relation to Patient______________
Birthdate______________SS#_________________ Date Employed_________________
Employer Work Phone____________________
Employer Address_______________________City______________State________Zip_____
Insurance Co. Group # ID_______________
Address City State________Zip ______
How much is your deductible? How much have you used?_________Max Annual Benefit_________

RESPONSIBLE PARTY

Name of Person Responsible for this Account_________________________________
Relation to Patient___________________Phone______________Birthdate____________
Address City State________Zip _______
Employer___________________________Work Phone___________ Email______________
Is the responsible party currently a patient in our office? ☐ Yes ☐ No

DENTAL HISTORY

Reason for today's visit ______________________________ Date of last dental visit ______________

Former Dentist and location ______________________________ Date of last dental X-rays ______________

CHECK IF YOU HAVE ANY OF THE FOLLOWING PROBLEMS

- ☐ Sensitivity to sweets
- ☐ Bad Breath
- ☐ Broken teeth/fillings
- ☐ Ulcers or growth in mouth
- ☐ Sensitivity when biting
- ☐ Bleeding Gums
- ☐ Grinding or clenching teeth
- ☐ Cold Sores
- ☐ Hot Sensitivity
- ☐ Periodontal treatment
- ☐ Popping/Clicking Jaw
- ☐ Collecting food between the teeth
- ☐ Cold Sensitivity
- ☐ Loose Teeth
- ☐ Jaw Pain / TMJ problems

How often do you floss______________________ How often do you brush ______________________

MEDICAL HISTORY

Physician's name and location ______________________________ Date of last visit ______________

Have you had any serious illness or operations? ☐ YES ☐ NO If yes, please describe including dates ______________________

____

____

Have you had a total joint replacement? * ☐ YES ☐ NO If yes, date and type of replacement______________________

Have you had a blood transfusion? ☐ YES ☐ NO If yes, date and explain ______________________

Do you or have you ever used tobacco products? ☐ YES ☐ NO If yes, type and frequency ______________________

Do you drink alcoholic beverages? ☐ YES ☐ NO If yes, frequency of use ______________________

Have you ever taken bisphosphonate drugs (Fosamax, Boniva, Actonel, Zometa)? ☐ YES ☐ NO If yes, duration & type ______________

Have you recently traveled outside the United States or lived in concentrated housing? ☐ YES ☐ NO If yes, where and when______________

WOMEN ONLY: Are you pregnant? ☐ YES ☐ NO Due Date____________Nursing? ☐ YES ☐ NO Taking birth control pills? ☐ YES ☐ NO

CHECK IF YOU HAVE OR HAVE HAD THE FOLLOWING PROBLEMS/CONDITIONS

- ☐ Anemia
- ☐ Arthritis/Rheumatism
- ☐ Artificial Joints*
- ☐ Asthma
- ☐ Artificial Cardiac Valves *
- ☐ Back Problems
- ☐ Excessive Bleeding/Bruising
- ☐ Blood Disease
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Cancer, type______________
- ☐ Chemical/Drug Dependency
- ☐ Circulatory Problems
- ☐ Chemotherapy
- ☐ Congenital Heart Disease *
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting or Dizziness
- ☐ GERD/ Heartburn
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Headaches, persistent
- ☐ Head Injuries
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Heart Transplant *
- ☐ Hepatitis, type ____
- ☐ Hemophilia
- ☐ HIV/AIDS
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Infective Endocarditis *
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorder
- ☐ Nervous Disorder
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Radiation Treatment
- ☐ Rheumatic Fever
- ☐ Seizure
- ☐ Respiratory Problems
- ☐ Sinus Problems
- ☐ STD/Venereal Disease
- ☐ Stomach Problems/Ulcer
- ☐ Stroke
- ☐ TMJ Problems/TMD
- ☐ Tuberculosis
- ☐ Chronic cough, longer than 3 weeks
- ☐ Coughing up blood/ Bloody Sputum
- ☐ Unexplained weight loss
- ☐ Unexplained night sweats
- ☐ None of the above
- ☐ Other : ______________________

LIST THE MEDICATIONS YOU ARE CURRENTLY TAKING (If you are not taking any medications, please write "NONE.")

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

ALLERGIES

- ☐ Aspirin
- ☐ Codeine
- ☐ Penicillin/Amoxicillin
- ☐ Sulfa
- ☐ None
- ☐ Erythromycin
- ☐ Iodine
- ☐ Local Anesthetic
- ☐ Latex
- ☐ Other______________________________

To the best of my knowledge, the above information is correct and complete. If there is ever a change in the above health information, I agree to inform the dentist or staff at the next appointment without fail. (If the parent or guardian is signing for a minor, please print your name in addition to signing.)

Patient Name ______________________________**Relationship to Patient** ______________________

Signature (Parent/Guardian if under 18) ______________________________ **Date**______________

Signature (FOR FUTURE UPDATES ONLY) ______________________________ **Date**______________

Signature (FOR FUTURE UPDATES ONLY) ______________________________ **Date**______________

410 Fleischmann Way, Suite A Carson City, NV 89703 Phone: (775) 884-3322
www.MarvelDental.com Email: MarvelDentalNV@gmail.com

FINANCIAL POLICY

PATIENTS WITH DENTAL INSURANCE COVERAGE

Please understand that your insurance policy is a contract between you and your insurance company. We are not a party to that contract. We will be glad to help you obtain the appropriate benefits from your insurance carrier as a courtesy to you. However, you are responsible for the payments of the account. Regarding insurance plans where we are a participation provider, all co-pays and deductibles are due prior to treatment. If your insurance company has not paid the claim within 45 days, the balance will be automatically transferred to you. In some cases, insurance carrier may pay for alternative benefits other than the treatment performed. In this case, you are responsible to pay for the difference. Even if you have dual coverage (which is possible when you and your spouse both have insurance) there may still be a portion that is your responsibility. All procedures involving lab work will require 50% down, and the remaining 50% balance will be due as treatment progresses. The balance must be paid before final delivery/insertion. If you are having extensive treatment over a period of time, we request payments during the course of treatment. Our financial coordinator will assist you in arranging a payment schedule.

PATIENTS WITHOUT DENTAL INSURANCE COVERAGE

Patients without dental insurance coverage are required to pay for service as rendered. We accept Cash, Check, Mastercard, Visa, or Debit/ATM cards. We also arrange pre-payments and no-interest financing through Care Credit (www.carecredit.com)

OFFICE POLICY CONCERNING SCHEDULING APPOINTMENTS

When you make an appointment, we reserve that time for you. We understand that extreme or unavoidable emergencies or circumstances do arise which may require you to cancel your appointment. We reserve the right to charge for any appointment(s) broken without a 24 hour notice. The charge for missed appointments will be $25. Initials______________ Date______________

BILLING POLICY

Check returned unpaid from bank is subject to a $35 service fee.

Accounts delinquent more than 90 days from the billing are subject to a 1.5% per month (18% annually) finance charge. If your account is sent to our collection agency you will be responsible for the 35% collection fee of balance.

We welcome you to our office and want to provide you with the best dental care possible. If you have any questions regarding our financial guidelines and your treatment, please don't hesitate to ask. We are here to help you any way we can!

I HAVE READ AND UNDERSTAND MARVEL DENTAL, Ltd.'s FINANCIAL POLICY, SCHEDULING POLICY AND BILLING POLICY.

Signature of Patient or Parent/Guardian ____ Date_____________________________

Print Patient Name____ Print Name of Parent/Guardian______________________________________

Jamie Marvel, DDS
410 Fleischmann Way, Suite A
Carson City, NV 89703
PH: (775) 884-3322
Email: MarvelDentalNV@Gmail.com

NOTICE OF PRIVACY PRACTICES

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Protecting your confidential health information is important to us! We take the Federal HIPAA – Health Insurance Portability and Accountability Act laws seriously in order to protect the privacy of your health information.

HOW YOUR HEALTH INFORMATION MAY BE USED

We will use and communicate your health information only for the purposes of providing your treatment, obtaining payment, and conducting health care operations. Your health information will not be used for other purposes unless we have asked for and been voluntarily given your written permission.

To Provide Treatment

We will use your health information within our office to provide you with the best dental care possible. This may include administrative and clinical office procedures designed to optimize scheduling and coordination of care between hygienist, dental assistant, dentist, and business office staff. In addition, we may share your health information with physicians, referring dentists, clinical and dental laboratories, pharmacies or other health care personnel providing you treatment.

To Obtain Payment

We may include your health information with an invoice used to collect payment for treatment you receive in our office. We may do this with insurance forms filed for you in the mail or sent electronically. We will be sure to only work with companies with a similar commitment to the security of your health information.

To Conduct Health Care Operations

Your health information may be used during performance evaluations of our staff. Some of our best teaching opportunities use clinical situations experienced by patients receiving care at our office. As a result, heath information may be included in training programs for students, interns, associates, and business and clinical employees. It is also possible that health information will be disclosed during audits by insurance companies or government appointed agencies as part of their quality assurance and compliance reviews. Your health information may be reviewed during the routine process of certification, licensing or credentialing activities.

In Patient Reminders

Since regular care is very important to your oral and general health, we will remind you of a scheduled appointment or that it is time for you to contact us and make an appointment. Additionally, we may contact you to follow up on your care and inform you of treatment options or services that may be of interest to you or your family.

These communications are an important part of our philosophy of partnering with our patients to be sure they receive the best preventative and restorative care modern dentistry can provide. They may include postcards, letters, telephone reminders, or email.

Abuse

It is our duty to notify government authorities if we believe a patient is the victim of abuse, neglect or domestic violence. We will make this disclosure only with the patient's agreement or when we are compelled by our ethical judgment and believe we are required or authorized to do so by law.

Public Health and National Security

We may be required to disclose health information to Federal officials or military authorities when this information is necessary to complete an investigation related to public health or national security. Health information can be important when the government believes that the public safety could benefit. The information could lead to control or prevention of an epidemic or the understanding of new side effects or a drug treatment or medical device.

For Law Enforcement

As permitted or required by State or Federal law, we may disclose your health information to a law enforcement official for certain law enforcement purposes including, under certain limited

circumstances, if you are a victim of a crime or in order to report a crime.

Family, Friends, and Caregivers

We may share your health information with those you tell us will be helping you with your home hygiene, treatment, medications, or payment. In the case of an emergency where you are unable to tell us what you want, we will use our very best judgment when sharing your health information only when it will be important to those participating in providing your care.

Authorization to Use or Disclose Health Information

Other than is stated above or where Federal, State or Local law requires us, we will not disclose your health information other than with your written authorization. You may revoke that authorization in writing at any time.

PATIENT RIGHTS

Restrictions

You have the right to request restrictions on certain uses and disclosures of your health information. Our office will make every effort to honor reasonable restriction preferences from our patients.

Confidential Communications

You have the right to request that we only communicate with you in a certain way. You may request that we only communicate your health information privately with no other family members present or through mailed communications that are sealed. We will make every effort to honor your reasonable request for confidential communication.

Inspect and Copy Your Health Information

You have the right to read, review, and copy your health information, including your complete chart, x-rays, and billing record. We may need to charge you a reasonable fee for duplication and assembly costs. If you would like a copy of your health information, please let us know.

Amend Your Health Information

You have the right to ask us to update or modify your records if you believe your health information records are incorrect or incomplete. We will be happy to accommodate your request as long as our office maintains this information. Please provide us with your request in writing and describe your reason for the change.

Documentation of Health Information

You have the right to ask us for a description of how and where your health information was used by our office for any reason other than for treatment, payment or health operations. Our documentation procedures will enable us to provide your health information for at least the past 5 years in accordance with subsection 1 and 7 NRS 629.051. Please let us know in writing the time period for which you are interested. We may need to charge you a reasonable fee for duplication and assembly costs.

Request a Paper Copy of this Notice

You have the right to obtain a copy of this Notice of Privacy Practices directly from our office at any time. Stop by or give us a call, and we will mail or email a copy to you.

We are required by law to maintain the privacy of your health information and to provide to you and your representative this Notice of our Privacy Practices. We are required to practice the policies and procedures described in this notice, but we do reserve the right to change the terms of our Notice. If we change our privacy practices we will provide you with a revised Notice.

You have the right to express complaints to us or to the Secretary of Health and Human Services if you believe your privacy rights have been compromised. We encourage you to express any concerns you may have regarding the privacy of your information.

NOTICE OF PRIVACY PRACTICES

PATIENT ACKNOWLEDGMENT

I, ______________________________________ ,

Print patient name

acknowledge that I have received a Notice of Privacy Practices from Marvel Dental, Ltd.

____

Signature (patient or parent/guardian)

____

Print parent/guardian name

Thank you very much for taking the time to review this notice. If you have any questions, we want to hear from you!