Welcome to Clear Creek Dental

Name_____Date_____

Social Security _____Date of Birth_____

Mailing Address_____E-mail_____

City_____State_____Zip code_____

Home phone_____Work_____Cell_____

Employer_____Occupation_____

Primary Dental Insurance_____Group #_____

Secondary Insurance_____Group#_____

Spouse or Parent Name_____

Subscriber's Social Sec. #_____ Date of Birth_____

Subscriber's Employer_____Occupation_____

Person to contact in case of emergency? _____

Whom may we thank for referring you to our office? _____

Please read and sign the following:

I authorize payment by my insurance company directly to *Clear Creek Dental*. I understand that I am responsible for all costs of dental treatment regardless of what my insurance company pays. I herby authorize *Clear Creek Dental* to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right of *Clear Creek Dental* to release my dental/medical histories and other information about my dental treatment to third party payers and/or other health professionals. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. If payments are not received by agreed upon dates, a 1.5 % finance charge (18% APR) may be added to my account.

I have received a copy of this office's Notice of Privacy Practices

Signed_____Date_____

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.

Are you under a physician's care now? If yes, please explain_____

Have you ever been hospitalized or had major operation? If yes, please explain_____

Have you ever had a serious head or neck injury? If yes, please explain_____

Are you taking medications, pills or drugs? If yes, please explain_____

Do you take, or have taken, Phen-Fen or Redux? _____

Have you ever taken Fosamax, Bonivia, Actonel or any other medications containing bisphosphonates_____

Are you on a special diet? _____

Do you use tobacco? _____Do you use controlled substances? _____

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 anesthetic___ Sulfa Drugs____

Other, please explain_____

Do you have, or have had, any of the following? Please check only the ones that apply.

Aids/HIV positive___	Breathing Problem___	Easily Winded___	Heart Attack/Failure___
Alzheimer's disease___	Bruise Easily___	Emphysema___	Heart Murmur___
Anaphylaxis___	Cancer___	Epilepsy___	Heart Pacemaker___
Anemia___	Chemotherapy___	Excessive Thirst___	Heart Trouble/Disease___
Angina___	Chest Pains___	Fainting Spells/Dizziness___	Herpes___
Arthritis/Gout___	Cold Sores/Fever___	Frequent Cough___	Hemophilia___
Artificial Heart Valve___	Congenital Heart Disorder___	Frequent Diarrhea___	Hepatitis A, B or C___
Artificial Joint___	Convulsions___	Frequent Headaches___	High Blood Pressure___
Asthma___	Cortisone Medicine___	Genital Herpes___	Hives or Rash___
Blood Disease___	Diabetes___	Glaucoma___	Hypoglycemia___

Blood Transfusion___	Drug addiction___	Hay Fever___	Irregular Heartbeat___
Kidney problems___	Renal Dialysis___	Stroke___	Pain in Jaw Joints___
Leukemia___	Rheumatic Fever___	Swelling of Limbs___	Parathyroid Disease___
Liver Disease___	Rheumatism___	Thyroid Diseases___	
Low Blood Pressure___	Scarlet Fever___	Tonsillitis___	
Lung Disease___	Shingles___	Tuberculosis___	
Mitral Valve___	Sickle Cell Disease___	Tumors or Growths___	
Psychiatric Care___	Sinus Trouble___	Ulcers___	
Radiation Treatments___	Spina Bifida___	Venereal Disease___	
Recent Weight Loss___	Stomach/Intestinal Disease___	Yellow Jaundice___	

Have you ever had any serious illness not listed above? If yes, please explain_____

_____

_____

_____

_____

_____

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.

Signature of Patient, Parent, or Guardian_____**Date**_____

CLEAR CREEK DENTAL

Financial Policy

Dear Valued Patient:

In order to keep fee increases to a minimum and continue to provide the best quality care for our patients, our dental office will be implementing a new financial payment policy.

We now ask that patients pay for their treatment with one of the following options at the time of service:

- Cash
- Check
- Credit card- Visa, MasterCard, American Express, Discover
- Care Credit

Patients with Dental Insurance: We will continue to submit your insurance. However, we ask that you pay your insurance co-payment at the time of service. Insurance co-payments may change according to the procedures performed and your policy that you have with your employer. We cannot be responsible for services not covered or balances that have not been paid by your insurance. ***Legally you are responsible for your account regardless of your balance. Please be certain of your commitment to our office prior to starting any dental treatment.***

Preventive- co-payment is contingent upon individual policies per your employer

Basic- 20% to 30 % is required

Major- 50% to 60 % is required

Note: Any insurance plan that pays directly to the patient requires payment in full at the time of service, unless prior financial arrangements have been made.

Truth and Lending: Late charges or finance charges will be assessed if payment is not received by the 20th of each month. Finance charges are assessed on all accounts with balances not paid within 60 days at a rate of 1.5%.

We appreciate your understanding of this policy. We look forward to continuing to serve you and your family's dental health needs.

CLEAR CREEK DENTAL

Appointments are reserved especially for you. We require a 48 hour notice if you need to reschedule or cancel. An $80.00-$300.00 broken appointment or late cancellation fee will be charged, depending on the type of appointment, if less than 48 hour notice is given. _____Initial

_____ _____

Signature of Responsible party or Legal Guardian Date

NOTICE OF PRIVACY PRACTICES

CLEAR CREEK DENTAL
Gregory Carman, D.M.D.
3790 Highway 395, Ste. 103
CARSON CITY, NV 89705
Phone: **(775) 267-2244**
Fax: **(775) 267-2115**

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This Notice describes how we protect your health information and what rights you have regarding it.

TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

The most common reason why we use or disclose your health information is for treatment, payment or health care operations. Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you; examining your teeth; prescribing medications and faxing them to be filled; referring you to another doctor or clinic for other health care or services; or getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose your health information for payment purposes are: asking you about your health or dental care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Health care operations" mean those administrative and managerial functions that we have to do in order to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.

We routinely use your health information inside our office for these purposes without any special permission. If we need to disclose your health information outside of our office for these reasons, we usually will not ask you for special written permission.

USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

- when a state or federal law mandates that certain health information be reported for a specific purpose;
- for public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the federal Food and Drug Administration regarding drugs or medical devices;
- disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence;
- uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws;
- disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies;
- disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else;

disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations;
uses or disclosures for health related research;
uses and disclosures to prevent a serious threat to health or safety;
uses or disclosures for specialized government functions, such as for the protection of the president or high ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service;
disclosures of de-identified information;
disclosures relating to worker's compensation programs;
disclosures of a "limited data set" for research, public health, or health care operations;
incidental disclosures that are an unavoidable by-product of permitted uses or disclosures;
disclosures to "business associates" who perform health care operations for us and who commit to respect the privacy of your health information.

Unless you object, we will also share relevant information about your care with your family or friends who are helping you with your dental care.

APPOINTMENT REMINDERS

We may call or write to remind you of scheduled appointments, or that it is time to make a routine appointment. We may also call or write to notify you of other treatments or services available at our office that might help you. Unless you tell us otherwise, we will mail you an appointment reminder on a post card, and/or leave you a reminder message on your home answering machine or with someone who answers your phone if you are not home.

OTHER USES AND DISCLOSURES

We will not make any other uses or disclosures of your health information unless you sign a written "authorization form." The content of an "authorization form" is determined by federal law. Sometimes, we may initiate the authorization process if the use or disclosure is our idea. Sometimes, you may initiate the process if it's your idea for us to send your information to someone else. Typically, in this situation you will give us a properly completed authorization form, or you can use one of ours. If we initiate the process and ask you to sign an authorization form, you do not have to sign it. If you do not sign the authorization, we cannot make the use or disclosure. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it. Revocations must be in writing. Send them to the office contact person named at the beginning of this Notice.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

The law gives you many rights regarding your health information. You can:

ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or health care operations. We do not have to agree to do this, but if we agree, we must honor the restrictions that you want. To ask for a restriction, send a written request to the office contact person at the address, fax or E Mail shown at the beginning of this Notice.

ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using E mail to your personal E Mail address. We will accommodate these requests if they are reasonable, and if you pay us for any extra cost. If you want to ask for confidential communications, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.

ask to see or to get photocopies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying. For the most part, however, you will be able to review or have a copy of your health information within 30 days of asking us (or sixty days if the information is stored off-site). You may have to pay for photocopies in advance. If we deny your request, we will send you a written explanation, and instructions about how to get an impartial review of our denial if one is legally available. By law, we can have one 30 day extension of the time for us to give you access or photocopies if we send you a written notice of the extension. If you want to review or get photocopies of your health information, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.

ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. We will send the corrected information to persons who we know got the wrong information, and others that you specify. If we do not agree, you can write a statement of your position, and we will include it with your health information along with any rebuttal statement that we may write. Once your statement of position and/or our rebuttal is included in your health information, we will send it along whenever we make a permitted disclosure of your health information. By law, we can have one 30 day extension of time to consider a request for amendment if we notify you in writing of the extension. If you want to ask us to amend your health information, send a written request, including your reasons for the amendment, to the office contact person at the address, fax or E mail shown at the beginning of this Notice.

get a list of the disclosures that we have made of your health information within the past six years (or a shorter period if you want). By law, the list will not include: disclosures for purposes of treatment, payment or health care operations; disclosures with your authorization; incidental disclosures; disclosures required by law; and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law we can have one 30 day extension of time if we notify you of the extension in writing. If you want a list, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.

get additional paper copies of this Notice of Privacy Practices upon request. It does not matter whether you got one electronically or in paper form already. If you want additional paper copies, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.

OUR NOTICE OF PRIVACY PRACTICES

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office, have copies available in our office, and post it on our Web site.

COMPLAINTS

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office contact person at the address, fax or E mail shown at the beginning of this Notice. If you prefer, you can discuss your complaint in person or by phone.

FOR MORE INFORMATION

If you want more information about our privacy practices, call or visit the office contact person at the address or phone number shown at the beginning of this Notice.

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of Dr. Carman's Notice of Privacy Practices.

Patient name _____

Signature _____ Date _____

Informed Consent for
Controlled Substance Therapy for Pain

In Nevada, per Assembly Bill 474, prescribers must inform their patients of information regarding the treatment of pain with the use of controlled substance. It is important that you review the following information carefully and request additional information you may need to make an informed choice about the medication(s) prescribed. **Please review the information listed here and initial each item.**

__I understand that I am being prescribed medications, including controlled substances for the treatment of pain.

__I understand that all pain medications, including controlled substances have different benefits and risks in the treatment of my symptoms. I have been advised of the potential risks and benefits of treatment using controlled substances.

__I understand that prescription controlled substances can carry serious risks of addiction and overdose, especially with prolonged use.

__ I understand that I am not to use the controlled substance prescribed to me in conjunction with drugs or alcohol, or other medications (unless otherwise directed by my prescriber).

__Before I was prescribed this pain medication, I was advised regarding non-opioid alternative means of treatment for my symptoms, including but not limited to anti-inflammatories (i.e. Aleve, Tylenol, ibuprofen, etc.)

__I understand that when I take controlled substance(s), I may experience certain reactions or side effects that could be dangerous, including, but not limited to, sleepiness or sedation, constipation, nausea, itching, allergic reactions, problems with thinking clearly, slowing of my reactions, or slowing of my breathing.

__I understand that when I take controlled substance(s), it may not be safe for me to drive a car, operate machinery, or take care of other people. If I feel sedated, confused or otherwise impaired by these medications, I understand that I should not do things that would put myself or other people at risk for being injured.

__ I understand that when I take controlled substances, I may become physical dependent of them, meaning my body will become accustomed to taking the medications every day, and I would experience withdrawal sickness if I stop them or cut back on them too quickly. Withdrawal symptoms feel like having the flu, and may include abdominal pain, nausea, vomiting, diarrhea, sweating, body aches, muscle cramps, runny nose, yawning, anxiety, and sleep problems.

--I understand that I may become addicted to controlled substances and require additional treatment if I cannot control how I am using them, or if I continue to use them for a prolonged period of time. I have discussed with my prescriber the proper use of the controlled substance.

__I understand that anyone can develop an addiction to pain medications, but people who have had problems with mental illness with controlling drug or alcohol use in the past or who have a parent or sibling who has had drug or alcohol abuse problems are at higher risk. I have told my prescriber if I or anyone in my family has had any of these types of problems.

__I understand that I must store prescriptions in a secure place and out of reach of children, other family members and others, and/or use a locked medicine cabinet. To safely dispose of unused medications, I can return the unused medications in the bottle to a local pharmacy, a ,local drug-take back day, or a local police or sheriff substation in my community, or I may safely dispose of them by dissolving them in a Dettera pouch. I understand that I am to dispose of unused medications into the toilet or sink.

__I understand that my doctor may not be permitted to refill my medication via telephone and, therefore, any requests for refills may require a consultation appointment. I understand that my doctor may decline to refill my prescription if he/she believes it to be medically unnecessary and/or harmful to my well-being. I understand that I am being prescribed a controlled substance for a short duration and that prescriptions for additional periods of time may require additional consultation, assessment and agreements.

__ I understand that due to the risk of possible overdose resulting from of controlled substances, the opioid overdose antidote naloxone (Narcan) is now available without prescription. I may obtain naloxone (Narcan) from a pharmacist.

__For Women: It is my responsibility to tell my prescriber immediately if I think I am pregnant or if I am thinking about getting pregnant. I understand the risk to a fetus of chronic exposure to controlled substances during pregnancy, including, without limitation, the risk of fetal dependency on the controlled substance, neonatal abstinence syndrome, neurologic and heart problems in the baby, prematurity, and fetal or neonatal death.

Informed Consent:

I understand each of the statements written here and by signing give my consent for treatment of my pain condition with medications, including controlled substances. I have had the opportunity to ask any questions that I may have regarding my treatment of pain with medications, including controlled substances, and am satisfied that my questions have been answered.

_____	_____	_____
Patient Printed Name	Patient Signature	Date

Unemancipated Minor:
As the parent/guardian, I have discussed with the prescriber the risks that the minor will abuse or misuse the controlled substance or divert the controlled substance for use by another person and ways to detect such abuse, misuse or diversion.

_____	_____	_____
Parent/Guardian printed name	Parent/Guardian Signature	Date