



# ALFORD PEDIATRIC & GENERAL DENTISTRY

Patient's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Sex M F

**D  
E  
N  
T  
A  
L**

Y N When was your last dental visit and by whom? \_\_\_\_\_

Y N When do you brush your teeth?  Morning  Between Meals  Bedtime

Y N Do you floss daily?

Y N Do you smoke or chew tobacco? (check all that apply)

Smoke  Chew Tobacco  Previously smoked/chewed tobacco and quit

Y N Do you have any dental pain?

If yes, please describe the pain: \_\_\_\_\_

Y N Do you like your smile?

If no, what are the specific esthetic concerns you would like us to address? \_\_\_\_\_

### Please answer every question

Y N Do you have a Doctor (Physician)?

Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Y N Do you take any medication?

If yes, please list: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**M  
E  
D  
I  
C  
A  
L**

Y N Do you have any allergies to medication, food, latex or other materials?

If yes, please list: \_\_\_\_\_

Y N Have you ever been admitted to a hospital, had surgery or a serious illness or injury?

If yes, please list: \_\_\_\_\_

\_\_\_\_\_

Do you have a history of any of the following (circle all that apply):

Y N Heart Murmur

Y N Bleeding Disorders

Y N Heart Disease

Y N Anemia

Y N Asthma

Y N Transfusions

Y N Reactive Airway Disease

Y N HIV

Y N Tuberculosis

Y N Immuno-compromised Conditions

Y N Epilepsy

Y N Diabetes

Y N Seizures

Y N Lupus

Y N Cerebral Palsy

Y N Arthritis

Y N Convulsions

Y N Autoimmune Diseases

Y N Shunts

Y N Premature Birth

Y N Sight Concerns

Y N Liver Disease (hepatitis, jaundice, etc)

Y N Hearing Concerns

Y N Kidney Concerns (Stones)

Y N Speech Concerns

Y N Stomach/GI Concerns

Y N Cancer (Leukemia, Tumors)

Y N Skin/Bone/Muscle Disorders

Y N Attention Disorders (ADD, ADHD, etc)

Y N Snoring

Y N Sensory Disorders (Autism Spectrum)

Y N Any other conditions we should be made aware of: \_\_\_\_\_

If you answered Yes to any of the above questions, please explain: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Signature

Date

Relationship to Patient



**ALFORD PEDIATRIC &  
GENERAL DENTISTRY**  
**Insurance Information**

**PATIENT INFORMATION**

Name (Last, First, MI): \_\_\_\_\_ DOB: \_\_\_\_\_  
Gender:  Male  Female Social Security #: \_\_\_\_\_ Marital Status:  Single  Married  Divorced  Widowed  
Home Phone #: \_\_\_\_\_ Work #: \_\_\_\_\_ Cell #: \_\_\_\_\_ Other #: \_\_\_\_\_  
Email Address: \_\_\_\_\_ Is it OK to Text and/or email you?  YES  NO Initials \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_ Work #: \_\_\_\_\_  
Have you or any member of your family been a patient at this office before?  YES  NO  
If yes, please give us their name(s): \_\_\_\_\_

Who may we thank for recommending our office to you? \_\_\_\_\_  
Otherwise, how did you learn about our practice?  Google  Radio  Facebook  Other \_\_\_\_\_

**ACCOUNT RESPONSIBLE PARTY**

Person responsible for Account: \_\_\_\_\_ Currently a patient in our office?  Yes  No  
Social Security #: \_\_\_\_\_ DOB: \_\_\_\_\_ Drivers License: \_\_\_\_\_ State: \_\_\_\_\_  
Home Phone #: \_\_\_\_\_ Cell #: \_\_\_\_\_ Other #: \_\_\_\_\_ Email: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**PRIMARY DENTAL INSURANCE**

Insured's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Relation to Patient: \_\_\_\_\_  
Social Security #: \_\_\_\_\_ Member ID: \_\_\_\_\_ Effective Date: \_\_\_\_\_  
Insurance Carrier: \_\_\_\_\_ Phone #: \_\_\_\_\_ Employer: \_\_\_\_\_  
Group/Policy #: \_\_\_\_\_ Union/Group Name: \_\_\_\_\_ Local #: \_\_\_\_\_

**SECONDARY DENTAL INSURANCE**

Insured's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Relation to Patient: \_\_\_\_\_  
Social Security #: \_\_\_\_\_ Member ID: \_\_\_\_\_ Effective Date: \_\_\_\_\_  
Insurance Carrier: \_\_\_\_\_ Phone #: \_\_\_\_\_ Employer: \_\_\_\_\_  
Group/Policy #: \_\_\_\_\_ Union/Group Name: \_\_\_\_\_ Local #: \_\_\_\_\_



6255 Sharlands Ave, Ste 3  
Reno, NV 89523  
(775) 339-3015  
alfordsmiles.com

### **FINANCIAL POLICY**

Payment for dental services is due at the time treatment is provided. If you have insurance, this payment typically includes the deductible, applicable coinsurance, and services not covered by your plan. We accept cash, personal checks, debit cards, and most major credit cards.

As a service to our patients we accept most, but not all, dental insurance programs. If we have received all of your insurance information on the day of the appointment, we will be happy to file your claim for you. You will be responsible for paying in full all services rendered if we are unable to verify your insurance information before treatment. We file all insurance electronically, so your insurance company will receive each claim within days of the treatment. Insurance payments are ordinarily received within 30 days from the time of filing a claim. You are responsible for any balance on your account after 30 days. If you have not paid your balance within 60 days, a re-billing fee of 1.5% will be added to your account each month until the outstanding balance is paid. We will be glad to send a refund to you if your insurance pays us. If for any reason the account is turned over to an attorney or collection agency for collection, an additional charge of 33-1/3% will be added to cover collection costs.

We strive to maximize your insurance benefits, but ultimately you are responsible for payment regardless of any insurance company's arbitrary determination. Please be aware that some or perhaps all of the services provided may or may not be covered by your insurance policy. The benefits paid by your insurance company are subject to eligibility, maximums, deductibles, limitations, and exclusions, which affect your patient portion.

You must be familiar with your insurance benefits. We will do our best to give you a rough estimate of patient co-payments and co-insurance balances, which will be collected at the time treatment is provided.

PLEASE UNDERSTAND that we file dental insurance as a courtesy to our patients. Your dental plan policy is a contract between you and your insurance company. We do not have a contract with your insurance company. Your plan and payment is your responsibility. We are not responsible for how your insurance company handles its claims, or for what benefits they pay on a claim. We do not guarantee what your insurance will or will not do with each claim. A plan is not a guarantee of payment; it often does not cover all the costs involved in treatment. We are not responsible for any errors in filing your insurance.

Our practice is dedicated to quality care and exceptional service. Our doctors and team spend extensive amounts of time preparing for your visit. Broken and missed appointments create scheduling problems for our team as well as other patients. If you find that you must change your appointment, we require a minimum of 48 hours notice so that we may make every effort to accommodate other patients. If proper notice is not received, we reserve the right to charge a fee of \$50.00 for every hour of allotted time canceled. We may also require deposits for future appointments.

I understand that I (or my child) am electing to be seen by Dr. Jacqueline Alford or Dr. Jason Alford today. I have read, understand, and agree to the above terms and conditions. I understand that I am responsible for payment for dental services provided in this office and any remaining balances on my (or my child's) account after 30 days, and may be charged for a violation of the policies as set forth above.

\_\_\_\_\_  
Patient/Legal Guardian Signature

\_\_\_\_\_  
Date

# NOTICE OF PRIVACY PRACTICES

As required by the Privacy Regulations Promulgated Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Please review this Notice carefully. The privacy of your health information is important to us. This Notice takes effect September 1, 2019, and will remain in effect until we replace it. We may update our privacy practices and the terms of this Notice at any time, subject to applicable law. You may request a copy of this Notice at any time.

## USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

**Treatment:** We may use or disclose your health information to another dentist or other healthcare provider providing treatment to you, or to family and friends you approve. We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party.

**Payment:** Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for services may require that your relevant protected health information be disclosed to your insurance company.

**Healthcare Operations:** We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

**Your Authorization:** In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. You also have the right to request restrictions on disclosure of PHI (Personal Health Information), or alternative means of communication to ensure privacy. Other Permitted and Required Uses and Disclosures Will Be Made Only with Your Consent, Authorization or Opportunity to Object, unless required by law. You may revoke this authorization, at any time, in writing, except to the extent that your physician or this organization has taken an action in reliance on the use or disclosure indicated in the authorization.

**Marketing Health-Related Services:** We will not use your health information for marketing communications without your written authorization.

**Required by Law:** We may use or disclose your health information when we are required to do so by law or national security activities.

**Abuse or Neglect:** We may disclose your health information to appropriate authorities when we suspect abuse or neglect.

**Contacting You:** We may use or disclose your health information to contact you about appointments and other matters, and to send you billing statements. We may contact you by mail, email, and telephone, and may leave messages at the telephone number you give us.

## **PATIENT RIGHTS**

**Access:** You have the right to inspect or copy your health information, with limited exceptions. If you request copies, we may charge you fees for expenses such as copies, staff time, and postage.

**Amendment:** You have the right to request that we amend your health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

**Restriction:** You have the right to request that we place additional restrictions on our use or disclosure of your health information, including uses or disclosures for treatment, payment, and health care operations, and to family members, friends, or others involved in your care or payment for your care. You must submit a written request that is signed and dated to the Privacy Officer at 6255 Sharlands Avenue, Suite 3, Reno, NV 89523. We are not required to agree to these additional restrictions, but if we do we will abide by our agreement (except in certain situations, such as to provide you with emergency treatment). You have a right to use another healthcare professional.

**Means of Communication:** You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, e.g., electronically.

**Accounting:** You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

**Changes:** We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

## **QUESTIONS AND COMPLAINTS**

If you want more information about our privacy practices or have questions, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us by contacting our Privacy Officer. You also may submit a written complaint to the U.S. Department of Health and Human Services. Upon request, we will provide you with the address to file your complaint.

We support your right to the privacy of your health information, and are required by law to maintain the privacy of protected health information. We will not retaliate in any way if you choose to file a complaint with us with the U.S. Department of Health and Human Services. A Privacy/Contact Officer has been designated for this office.

**Privacy Officer Contact Information:** 6255 Sharlands Avenue, Suite 3, Reno, NV 89523  
(775) 339-3015



**ALFORD PEDIATRIC &  
GENERAL DENTISTRY**

6255 Sharlands Avenue, Suite 3

Reno, NV 89523

(775) 339-3015

**PATIENT ACKNOWLEDGEMENT OF THE NOTICE OF PRIVACY PRACTICES  
AND CONSENT FOR USE AND DISCLOSURE OF  
PERSONAL HEALTH INFORMATION**

I, \_\_\_\_\_, acknowledge that I have received a written copy of Alford Pediatric & General Dentistry's ("Alford Dental") NOTICE OF PRIVACY PRACTICES.

I consent to the use and disclosure of my (and/or my child's) personal health information by Alford Dental for Treatment, Payment, Healthcare Operations, and pursuant to applicable law and/or further approval, as outlined in the NOTICE OF PRIVACY PRACTICES.

\_\_\_\_\_  
Signature of Patient/Parent/Legal Guardian

\_\_\_\_\_  
Date



## Consent to use photographs

6255 Sharlands Ave, Suite 3  
Reno, NV 89523  
775-339-3015 (Phone)

### ALFORD PEDIATRIC AND GENERAL DENTISTRY PHOTO RELEASE FORM

I hereby grant Alford Dental, PLLC (“Alford Pediatric and General Dentistry”) permission to use my likeness in a photograph, video, or other digital media (“photo”) in any and all of its publications, including web-based publications and educational materials, without payment or other consideration.

I understand and agree that all photos will become the property of Alford Pediatric and General Dentistry and will not be returned.

I hereby irrevocably authorize Alford Pediatric and General Dentistry to edit, alter, copy, exhibit, publish, or distribute these photos for any lawful purpose. In addition, I waive any right to inspect or approve the finished product wherein likeness appears.

I hereby hold harmless, release, and forever discharge Alford Pediatric and General Dentistry from all claims, demands, and causes of action which I, my heirs, representatives, executors, administrators, or any other persons acting on my behalf or on behalf of my estate have or may have by reason of this authorization.

**I HAVE READ AND UNDERSTAND THE ABOVE PHOTO RELEASE AND ACCEPT THE TERMS:**

Patient’s name, printed: \_\_\_\_\_

Signature of Patient: \_\_\_\_\_

Date \_\_\_\_\_