Vernon J. Lamborn, DDS, PC

Welcome to our practice!! We invite you to discuss with us any questions regarding our services. The best Dental health services are based on a friendly, mutual understanding between provider and patient.

Patient Information

(**Please Print**)

Today's Date ____/____/____

PATIENT INFORMATION

Patient's Last Name	First	Middle	❑ Mr. ❑ Miss ❑ Mrs. ❑ Ms.	Marital Status (Circle One) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	Prefers to be called:	Birth Date / /	Age	Sex ❑ M ❑ F

Street Address	City	State	ZIP Code	Social Security	Home Phone No. ( ) Cell Phone No. ( )

Mailing address (if different)	City	State	ZIP Code

Occupation	Employer	Employer Phone No. ( )

Whom may we thank for referring you to our practice:

Other Family Members Seen Here

e-mail address:

INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)

Person Responsible for Bill	Birth Date / /	Address (if different)	Home Phone No.
Is this person a patient here?	❑ Yes ❑ No		( )

Occupation	Employer	Employer Address	Employer Phone No. ( )

Is this patient covered by insurance? ❑ Yes ❑ No Name of Primary Ins:

Subscriber's Name	Subscriber's S.S. #	Birth Date / /	Group #	Policy #	

Patient's Relationship to Subscriber ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of Secondary Insurance (if **applicable**) Subscriber's Name	Group #	Policy #

Patient's Relationship to Subscriber ❑ Self ❑ Spouse ❑ Child ❑ Other

Secondary Subscriber's S.S. # Birth Date / /

IN CASE OF EMERGENCY

Name of Local Friend or Relative (not living at same address)	Relationship to Patient	Home Phone No. ( )	Work Phone No. ( )

TURN OVER, PLEASE

Dental Information

Reason for today's visit: ☐Exam ☐Emergency ☐Consultation
Are you in Pain? ☐No ☐Yes How Long?_____

Please indicate any of the following problems:

☐Discomfort, clicking or popping in jaw.
☐Red, swollen or bleeding gums.
☐Sensitive tooth, teeth, or gums.
☐Blisters/Sores in or around the mouth
☐Lost/Broken Filling(s)
☐Teeth grinding
☐Ringing in Ears
☐Broken/Chipped tooth
☐Stained teeth
☐Locking Jaw
☐Bad Breath

Other:_____
Do you require pre-medication? (Antibiotics prior to dental treatment) ☐Yes ☐No ☐Don't Know

Previous Dentist_____ Phone ( )_____

Last Dental Exam_____Last Dental x-rays_____
Times a day you brush?_____ Times a day you floss?_____
What type of tooth brush bristles do you use? ☐Soft ☐Medium ☐Hard

Medical History

Are you taking any of the following medications? ☐Nerve Pills ☐Pain killers (including aspirin)
☐ Muscle relaxers ☐Stimulants ☐ Blood Thinners ☐Tranquilizers ☐Insulin
☐**PLEASE LIST ANY OTHER MEDICATIONS YOU ARE CURRENTLY TAKING**_____
Do you have or ever had any of the following diseases or medical conditions?

Y N Heart Attack / Stroke
Y N Heart Surg/Pacemaker
Y N Heart Murmur
Y N Rheumatic Fever
Y N Mitral Valve Prolapse
Y N Artificial Valves
Y N Heart Disease
Y N Congenital Heart Defect
Y N Chest Pains
Y N Scarlet Fever
Y N Kidney Problems
Y N Liver Problems
Y N Respiratory Problems
Y N Sinus Problems
Y N Stomach Prob/Ulcers
Y N Psychiatric Problems
Y N Venereal Disease
Y N Alcohol/Drug Abuse
Y N Tuberculosis TB
Y N Jaw ProblemsTMJ/TMD
Y N Cancer/ Tumors
Y N Shingles
Y N Hepatitis
Y N HIV+/AIDS/ARC
Y N Arthritis/ Rheumatism
Y N Artificial Bones/Joints
Y N Emphysema
Y N Fainting/Seizures/Epilepsy
Y N Sever/Frequent Headaches
Y N Frequent Neck Pain
Y N Chemotherapy
Y N Asthma
Y N Difficulty Breathing
Y N Diabetes/Hypoglycemia
Y N Leukemia
Y N Anemia
Y N High/Low Blood Pressure (circle one)
Y N Bleed Problems
Y N Glaucoma
Y N Back Problems

Please List any other medical conditions you have or ever had: _____

Are you **allergic** to any of the following? ☐ Latex ☐ Penicillin/ Amoxicillin ☐Tetracycline ☐ Aspirin

☐Dental Anesthetics ☐Other: _____

Do you use tobacco? ☐ No ☐ Yes / How used?_____How much?_____How Long?

Please rate your general health from 1-10:_____Do you wear contact lenses? ☐ Yes ☐ No

For Women: Are you taking Birth Control pills? ☐ Yes ☐ No How many children have you had?_____
Are you Pregnant? ☐ No ☐ Yes/ How long? _____ Are you nursing? ☐ Yes ☐ No

- I understand that VERNON LAMBORN, DDS requires payment in full for all services rendered at the time of the visit, unless other arrangements have been made with the business manager. I further understand and agree that if the account is not paid within 90 days of the last date of service and no financial arrangements have been made, I will be personally responsible for any and all expenses incurred in the pursuit of collection of my account including any and all legal fees, costs of suit, and interest at the legal rate plus 2% over prime.
- Failure to give 24 hours notice when cancelling an appointment may result in a cancelation fee.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment, I also authorize the provider to release any information required to process insurance claims.

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Dr. Lamborn. I understand that I am financially responsible for any balance. I also authorize Vernon J. Lamborn, DDS, PC or insurance company to release any information required to process my claims.

X _____
PATIENT/GUARDIAN SIGNATURE DATE

URGENT

PLEASE READ AND CHECK ALL THAT APPLIES:

HAVE YOU EVER TAKEN A CLASS OF DRUGS CALLED BISPOSHONATES WHICH INCLUDE THE FOLLOWING DRUGS?

____FOSOMAX	____AREDIA	____ZOMETA
____ACTENOL	____BONIVA	____DIDRONEL

NOTE: IF PATIENT HAS BEEN ON ANY OF THESE DRUGS FOR 3 YEARS OR MORE THERE IS A .7 TO 1.0% CHANCES OF OSTEONECROSIS AFTER EXTRACTIONS. PATIENT WILL NEED TO HAVE A CTX TEST DONE (QUEST CODE #17406). IF THE RESULTS ARE LESS THAN 150 PG/ML THEN PATIENT SHOULD BE OFF MEDICATION FOR 6 MONTHS.

___ARE YOU CURRANTLY TAKING BLOOD THINNERS (INCLUDING ASPRIN)?

___HAVE YOU EVER HAD AN ALLERGIC REACTION TO ANY DENTAL OFFICE MATERIALS, SUCH AS LATEX OR ANESTHETIC?

___DO YOU HAVE ANY MEDICATION ALLERGIES?

___HAS YOUR MEDICAL DOCTOR EVER REQUIRED THAT YOU TAKE SPECIAL PRECAUTIONS FOR YOUR DENTAL TREATMENT, FOR EXAMPLE TAKING ANTIBIOTICS PRIOR TO TREATMENT?

___DO YOU HAVE AN ARTIFICIAL JOINT, MITRAL VALVE PROLAPSE, ARTIFICIAL VALVES, HEART MURMUR OR ANY OTHER HEART PROBLEMS?

___ARE YOU PREGNANT OR NURSING?

IF YOU CHECKED ANY QUESTIONS ABOVE PLEASE EXPLAIN BELOW:

_____

_____

_____

PATIENT SIGNATURE_____ **DATE**____/____/____

Vernon J. Lamborn, DDS, PC

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY:

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Vernon J. Lamborn, DDS, PC

Please read and sign only one option:

1) RIGHT TO REVOKE

You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will ***not*** affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and heath care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name:_____ Relationship to Patient:_____

OR

2) REVOCATION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will ***not*** affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____ Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

Vernon Lamborn DDS
8440 S. Eastern Ave., Ste B
Las Vegas, NV 89123
(702) 451-9111

CONSENT TO DISCUSS PATIENT INFORMATION

Patient:_____ Date_____

Date of Birth:____/____/____

Nevada state laws prevent this office from discussing patient information without express written consent from the patient. If you would like this office to be able to discuss your dental care with someone other than yourself, please list the name(s) of the individual(s) below. Please keep in mind that you can change this list at any time. Any person on the list must be able to verify your date of birth as an added security.

☐ **Do not discuss with anyone.**

OR

Name of person(s)	**Relationship to patient**
1._____	
2._____	
3._____	

Patient Signature:_____