Dayton Valley Dental Care

Dr. Julio Escobar, D.D.S, Ltd.
5 Pine Cone Rd. Suite 204
Dayton, NV 89403
775-246-2400

Here are some guidelines to help you understand our office philosophy. To better serve your needs, we strive for a clear, mutual understanding at all times.

If Dr. Escobar feels a certain procedure is better served by another Dentist or Specialist, he will refer you. Quality first!

Full mouth x-rays are necessary and required for the complete diagnosis of both periodontal and restorative needs.

Dr. Escobar diagnoses what he feels you need, NOT what insurance pays for.

In order to build a positive relationship with the patient, we do require that parents, relatives, and friends remain in the waiting room until the appropriate time.

We appreciate the value of your time, and except for emergency situations, you can expect us to be on time for you. We will appreciate the same courtesy.

Payment is due at the time of service. We accept personal checks, cash, Care Credit, Visa, American Express, Discover, and MasterCard.

If you find it necessary to change your appointment, we require 48 hours (working days) notice. Missed appointment charge is $50.00 for every hour we have reserved for you.

By signing this form, you agree to our office policy.

______________________________ ______________________

Patient/Guardian Signature Date

Have you or another family member been seen at this office? **Yes** ☐ **No** ☐

Patient Information

Patient Name: ______________________________ Date: __________
Last, First MI (Preferred Name)
Gender: __________ Family Status: __________
Social Security #: ______________________ Birth Date: ______________________
Phone (Home): __________ (Work): __________ Ext: ______ Best time to call: __________
Address: ____
Physical **Mailing**
____
City State Zip Code
EMAIL: ____

EMERGENCY CONTACT: **PHONE#**

Spouse or Responsible Party Information

The following is for: ☐ The patient's spouse ☐ The person responsible for payment ☐ Self see above

Name: ____
☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other __________
Social Security #: ______________________ Birth Date: ______________________
Phone (Home): __________ (Work): __________ Ext: ______ Best time to call: __________
Address: ____
Street Apartment #
____
City State Zip Code

CLOSEST RELATIVE NOT LIVING WITH YOU: PHONE#

Employment Information

The following is for: ☐ The patient ☐ The person responsible for payment

Employer Name: ______________________ Occupation: ______________________
Address: ____
Street City, State Zip Code Phone

Insurance Carrier: Self ☐ Spouse ☐ Other ☐

Referral Information

Whom may we thank for referring you to our practice? ☐ Another patient, friend ☐ Another patient, relative

☐ Office Sign ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work

Name of person or office referring you to our practice: ______________________________

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Any appointments that are failed, cancelled or rescheduled with less than 48 hours (working days) notice will incur a **$50.00 service charge per hour reserved** to the patient account. This fee must be paid in full prior to scheduling a future appointment.
Please Initial: __________

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. All patient portions will be due at time of service, this includes co-pays and deductible. Patients that carry **Delta Dental** will have fees due at the time of services rendered. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

Please be aware that all balances are due within 45 day, regardless if insurance has paid or not. A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days. After 90 days, all accounts will be turned over to a third-party collection. Any accounts requiring this action will incur all collection and legal cost.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I hereby authorize doctor or designated staff to take x-rays, study models, photographs and any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of my dental needs.

Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon and to employ such assistance as required to provide proper care.

I agree to use anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.
I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.
I have read the above conditions of treatment and payment and agree to their content.

______________________________ Date: __________ Relationship to Patient: ________
Signature of patient, parent or guardian

______________________________ Date: __________ Relationship to Patient: ________
Signature of guarantor of payment/responsible party

Medical History

Patient Name____

Have you been under the care of a medical doctor during the past two years?........................Yes/No
If yes, for what?____
Physician's Name____Phone__________________
Address______________________________City__________________State________Zip____________
Have you taken any medication or drugs during the past two years?...Yes/No
Are you taking any medication, drugs or pills now?..Yes/No
If yes, please list name and dosage____
Are you aware of having an allergic (or adverse reaction) to any medication or substance?.....Yes/No
If yes, please list____
Have you been a patient in the hospital during the past 5 years?..Yes/No
Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each of them.

Heart(Surgery, Disease, Attack)...Yes/No	Ulcers.......................................Yes/No	Implants/Cosmetic Surgery.........Yes/No
Chest Pain.....................................Yes/No	Diabetes....................................Yes/No	Hepatitis (A,B,C)..........................Yes/No
Congenital Heart Disease..............Yes/No	Thyroid Problems.......................Yes/No	A.I.D.S...Yes/No
Heart Murmur.................................Yes/No	Glaucoma...................................Yes/No	H.I.V Positive.................................Yes/No
High Blood Pressure.......................Yes/No	Contact Lenses...........................Yes/No	Cold Sores/Fever Blisters............Yes/No
Mitral Valve Prolapse.....................Yes/No	Emphysema................................Yes/No	Blood Transfusion..........................Yes/No
Artificial Heart Valve......................Yes/No	Chronic Cough............................Yes/No	Hemophilia/Sickle Cell Disease. Yes/No
Heart Pacemaker.............................Yes/No	Tuberculosis...............................Yes/No	Bruise Easily..................................Yes/No
Rheumatic Fever.............................Yes/No	Asthma.......................................Yes/No	Liver Disease/Yellow Jaundice....Yes/No
Arthritis/Rheumatism.....................Yes/No	Hay Fever...................................Yes/No	Neurological Disorder....................Yes/No
Cortisone Medicine........................Yes/No	Latex Sensitive...........................Yes/No	Epilepsy orSeizures.......................Yes/No
Swollen Ankles ....Yes/No	Allergies or Hives.......................Yes/No	Fainting or Dizzy Spells.................Yes/No
Stroke ....Yes/No	Sinus Trouble..............................Yes/No	Nervous/Anxious/Stress.................Yes/No
Diet(Special/Restricted)...............Yes/No	Radiation Therapy.......................Yes/No	Psychiatric/Psychological Care.....Yes/No
Artificial Joints(hips,knee,etc.)...Yes/No	Chemotherapy..............................Yes/No	Venereal Disease............................Yes/No
Kidney Trouble...............................Yes/No	Tumors...Yes/No	

Do you require an antibiotic prior to dental treatment?...Yes/No
Do you use more than two pillows to sleep?...Yes/No
Do you have or have you had any disease, conditions, or problems not listed?...Yes/No
If yes, please list____
Women. Are you: Pregnant? Yes,________Months No Nursing? Yes No Taking birth control pills? Yes No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency who may release such information to you. I will notify the doctor of any change in my health or medication.

Patient/Guardian
Signature____

_Dr._
Signature____Date_________________________

Patient Name

Medical Alert

DENTAL HISTORY

Welcome! So that we may provide you with the best possible care please complete both sides of this medical/dental history form. All information is completely confidential.

What is the reason for your visit today?____

____

Date of Last Dental Visit__________ **Last Dental Cleaning**__________ **Last Full Mouth X-rays**__________

What was done at your last dental visit?______________________________________

____

Previous Dentist's Name____

Address____________________________________ State__________ Zip__________

Telephone____

How often do you have dental examinations?________________________________

How often do you brush your teeth?__________________ How often do you floss?__________________

What other dental aids do you use? (water pik, electric toothbrush, toothpick, etc.)________________

Do you have any dental problems now? Yes No

If yes, please describe:____

Are any other your teeth sensitive to:
- Hot or cold? Yes No
- Sweets? Yes No
- Biting or Chewing? Yes No

Have you noticed any mouth odors or bad tastes? Yes No

Do you frequently get cold sores,blisters or any other oral lesions? Yes No

Do your gums bleed or hurt?

Have your parents experienced gum disease or tooth loss? Yes No

Have you noticed any loose teeth or change in your bite? Yes No

Do you?
- Clench or grind your teeth while awake or asleep? Yes No
- Mouth breath while awake or asleep? Yes No
- Have tired jaws, especially in the morning? Yes No
- Smoke/chew tobacco? Yes No

Have you ever had:
- Orthodontic treatment? Yes No
- Oral surgery? Yes No
- Periodontal treatment? Yes No
- A bite plate or mouth guard? Yes No
- A serious injury to the mouth or head? Yes No

If so, please describe, including cause____________

____

Have you experienced:
- Clicking or popping of the jaw? Yes No
- Pain (joint, ear, side of face)? Yes No
- Difficulty in opening or closing the mouth? Yes No
- Headaches, neckaches or shoulder aches? Yes No
- Sore muscles (neck, shoulders)? Yes No

Are you satisfied with your teeth's appearance?
- Do you like the color of your teeth? Yes No
- Are you happy with the size and spacing of your teeth? Yes No

Are you interested in changing your smile? Yes No

Would you like to keep all of your teeth all of your life? Yes No

Do you feel nervous about having dental treatment? Yes No

If so, what is your biggest concern?

Have you ever had an upsetting dental experience? Yes No

If yes, please describe____________________

____

Is there anything else about having dental treatment that you would like us to know? Yes No

If yes, please describe____

____

____

(Please complete other side)

Dayton Valley Dental Care

* You May Refuse to Sign This Acknowledgment*

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

Print Name:____

Signature:____

Date:____________________

You have my permission to discuss my dental appointments and treatment with the following people:

Name______________________________Relation________________

Name______________________________Relation________________

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

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