

PATIENT NAME _____ Date of Birth _____ Age _____
 Physical Address _____ How long _____
 Mailing Address _____ City _____ State _____ Zip _____
 Email _____ Social Security Number _____
 Home Phone _____ Cell Phone _____
 Employer _____ Years _____ Occupation _____ Work Phone _____
 Person to Contact in case of Emergency: Name _____ Phone _____
 Whom may we thank for referring you to our office? _____

SPOUSE INFORMATION

Name _____ Date of Birth _____ Age _____
 Address _____ City _____ State _____ Zip _____
 Home / Cell Phone _____ Social Security Number _____
 Employer _____ Years _____ Occupation _____ Work Phone _____

RESPONSIBLE PARTY INFORMATION

Relationship to Patient _____

Name _____ Date of Birth _____ Age _____
 Address _____ City _____ State _____ Zip _____
 Home / Cell Phone _____ Social Security Number _____
 Employer _____ Years _____ Occupation _____ Work Phone _____

INSURANCE INFORMATION

Insured's name _____ Birthdate _____ SSN _____

Primary Dental Insurance Plan _____ Insurance Company _____

Secondary Dental Insurance Plan _____ Insurance Company _____

MEDICAL HISTORY

Do you have or have you ever had:

YES NO

Anemia _____
 Diabetes _____
 Hepatitis _____
 High Blood Pressure _____
 Heart Condition _____
 Abnormal Bleeding _____
 Rheumatic Fever _____
 Are you HIV positive? _____
 Tuberculosis _____
 Have you had any other serious illnesses? _____
 Date of last Medical Exam _____
 Are you under the care of a physician? _____
 If so, for what reason? _____

Are you allergic to:

YES NO

Penicillin or other Antibiotics _____
 Anesthetic Type: _____
 Other drugs: _____
 Are you a smoker? How Much? _____
 What medications are you taking? _____

Do you have an artificial limb, joint, heart valve, pacemaker, screws, pins, rods or any other metal in your body? _____

If yes, please explain: _____

Are you pregnant? Yes _____ No _____ Due _____

Family Physician: _____

WE WILL NOT TREAT PATIENTS WITH ANY ACTIVE COMMUNICABLE DISEASES

I understand that I am financially responsible for this account. I understand that it is customary to pay for professional services when rendered.

I understand that insurance is a contract between me and my insurance company. I understand that my insurance company is not obligated to the dental office. The dental office will bill my insurance as a courtesy to me. The dental office will provide me with an insurance estimate prior to treatment. I understand that I am responsible for all fees related to treatment.

Insurance Authorization Signature On File: I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

I hereby authorize and direct payment of the dental benefits otherwise payable to me directly to G. Larry Leonakis, D.D.S., Inc.

CHIEF CONCERN: _____

DATE OF LAST DENTAL VISIT: _____ **DATE OF LAST DENTAL CLEANING:** _____

SIGNATURE _____ **DATE** _____

G. Larry Leonakis, DDS, Inc.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

YOU MAY REFUSE TO SIGN THIS

By signing below, I am stating that I have received a copy of this office's Notice of Privacy Practices.

Please Print Name

Signature

Date

FOR OFFICE USE ONLY

An attempt to obtain written acknowledgment of Receipt of Notice of Privacy was attempted, however could not be obtained because:

Individual refused to sign

Communication barriers prohibited obtaining the acknowledgment

An emergency situation prevented us from obtaining acknowledgement

Other

G. Larry Loeonakis, D.D.S., Inc.
374 South Roop Street, Carson City, NV 89701
(775)882-0635

Informed Consent General Dental Treatment

I understand that the following are possible risks and consequences to common dental procedures:

REACTION TO ANESTHESIA: I understand that to keep me comfortable while my tooth is being treated or extracted or if periodontal care is being performed, I will most likely receive a local anesthetic. I understand that this procedure is extremely safe but is an invasive procedure and there are some risks involved. I understand that on rare occasions I may have an allergic reaction to the anesthetic, which may require emergency medical attention, or find that it reduces my ability to control swallowing, which increases the chance of swallowing foreign objects during treatment. I understand that on rare occasions the injection may give an "electric shock" feeling on the tongue, lip, or teeth. I understand that this rarely has any lasting effect on the area. I understand that on rare occasions an injection may cause my heart to beat harder and faster than normal because of the very small dose of epinephrine in the solution and that this usually lasts for a short period of time. I understand that on rare occasions does numbness last for a long period of time and rarely lasts permanently.

STIFF OR SORE JAW JOINT: I understand that holding my mouth open during treatment may temporarily leave my jaw feeling stiff and sore and may make it difficult for me to open my mouth wide for several days. I understand that treatment may leave the corners of my mouth red or cracked for several days.

DRUGS AND MEDICATIONS: I understand that should it be necessary to prescribe medication or drugs, that antibiotics, analgesics, or other medications may on rare occasions cause allergic reactions. I understand that these reactions may be redness and swelling of tissues, pain, itching, vomiting, diarrhea, or anaphylactic shock. I understand that on rare occasions hospitalization is necessary. I understand that if I am given sedatives that they may make me drowsy temporarily or may reduce my coordination. I understand that ED drugs such as Viagra or Cialis should not be taken 48 hours before a dental procedure.

TREATMENT PLAN CHANGES: I understand that during treatment it may be necessary to change or add procedures because of conditions that may be found while working on the teeth or supporting tissues that were not discovered during the examination. I understand that a common change may be root canal therapy following a routine restorative procedure.

REMOVAL OF TEETH: I understand that alternatives to removing teeth will be explained to me. I understand that if alternatives exist they may be root canal treatment, crowns or other restorations, or periodontal therapy. I understand that removing a tooth may not always remove all the infection that may be present and it may be necessary to have additional treatment. I understand that some of the risks involved with having teeth removed may be pain, swelling, spread of infection, dry socket, fractured jaw, or indefinite loss of feeling in teeth, lips, tongue or surrounding tissues. I understand that I may need treatment by a specialist if complications arise during or after treatment. I understand that the cost of this treatment would be my responsibility.

FILLINGS: I understand that if I have had fillings placed that I must exercise care during the first twenty four hours to avoid breakage of the fillings. I understand that a more extensive filling than originally diagnosed may be required due to additional decay not visible on an x-ray. I understand that significant sensitivity may be a common after effect of a recent filling. I understand that a filling weakens the tooth and that a thin weak area of the tooth is susceptible to fracture which may require additional treatment.

CONSEQUENCES OF NOT PERFORMING TREATMENT: I understand that the proposed treatment will help to relieve my symptoms. I understand that if no treatment is performed that I would continue to experience symptoms. I understand that these symptoms may include pain, infection, deterioration of the bone surrounding my teeth, changes to my bite, discomfort of my jaw joint, and the premature loss of teeth. I understand that infection can threaten my health.

I understand that dentistry is not an exact science and that neither Dr. Larry Leonakis nor associates can guarantee results. I acknowledge that no guarantee or assurance has been made regarding dental treatment which I may request or authorize. I understand that by signing below I acknowledge that I have received adequate information about the risks of common dental treatment. I have had all of my questions answered. I understand this form.

_____ I understand these risks and consequences and give my consent for treatment.

_____ I understand these risks and consequences and refuse to give my consent for treatment.

Patient Signature

Patient Name

Date

Dentist Signature

Witness Signature

Date

G. Larry Loeonakis, D.D.S., Inc.
374 South Roop Street, Carson City, NV 89701
(775)882-0635

Informed Consent General Dental Treatment

I understand that the following are possible risks and consequences to common dental procedures:

REACTION TO ANESTHESIA: I understand that to keep me comfortable while my tooth is being treated or extracted or if periodontal care is being performed, I will most likely receive a local anesthetic. I understand that this procedure is extremely safe but is an invasive procedure and there are some risks involved. I understand that on rare occasions I may have an allergic reaction to the anesthetic, which may require emergency medical attention, or find that it reduces my ability to control swallowing, which increases the chance of swallowing foreign objects during treatment. I understand that on rare occasions the injection may give an "electric shock" feeling on the tongue, lip, or teeth. I understand that this rarely has any lasting effect on the area. I understand that on rare occasions an injection may cause my heart to beat harder and faster than normal because of the very small dose of epinephrine in the solution and that this usually lasts for a short period of time. I understand that on rare occasions does numbness last for a long period of time and rarely lasts permanently.

STIFF OR SORE JAW JOINT: I understand that holding my mouth open during treatment may temporarily leave my jaw feeling stiff and sore and may make it difficult for me to open my mouth wide for several days. I understand that treatment may leave the corners of my mouth red or cracked for several days.

DRUGS AND MEDICATIONS: I understand that should it be necessary to prescribe medication or drugs, that antibiotics, analgesics, or other medications may on rare occasions cause allergic reactions. I understand that these reactions may be redness and swelling of tissues, pain, itching, vomiting, diarrhea, or anaphylactic shock. I understand that on rare occasions hospitalization is necessary. I understand that if I am given sedatives that they may make me drowsy temporarily or may reduce my coordination. I understand that ED drugs such as Viagra or Cialis should not be taken 48 hours before a dental procedure.

TREATMENT PLAN CHANGES: I understand that during treatment it may be necessary to change or add procedures because of conditions that may be found while working on the teeth or supporting tissues that were not discovered during the examination. I understand that a common change may be root canal therapy following a routine restorative procedure.

REMOVAL OF TEETH: I understand that alternatives to removing teeth will be explained to me. I understand that if alternatives exist they may be root canal treatment, crowns or other restorations, or periodontal therapy. I understand that removing a tooth may not always remove all the infection that may be present and it may be necessary to have additional treatment. I understand that some of the risks involved with having teeth removed may be pain, swelling, spread of infection, dry socket, fractured jaw, or indefinite loss of feeling in teeth, lips, tongue or surrounding tissues. I understand that I may need treatment by a specialist if complications arise during or after treatment. I understand that the cost of this treatment would be my responsibility.

FILLINGS: I understand that if I have had fillings placed that I must exercise care during the first twenty four hours to avoid breakage of the fillings. I understand that a more extensive filling than originally diagnosed may be required due to additional decay not visible on an x-ray. I understand that significant sensitivity may be a common after effect of a recent filling. I understand that a filling weakens the tooth and that a thin weak area of the tooth is susceptible to fracture which may require additional treatment.

CONSEQUENCES OF NOT PERFORMING TREATMENT: I understand that the proposed treatment will help to relieve my symptoms. I understand that if no treatment is performed that I would continue to experience symptoms. I understand that these symptoms may include pain, infection, deterioration of the bone surrounding my teeth, changes to my bite, discomfort of my jaw joint, and the premature loss of teeth. I understand that infection can threaten my health.

I understand that dentistry is not an exact science and that neither Dr. Larry Leonakis nor associates can guarantee results. I acknowledge that no guarantee or assurance has been made regarding dental treatment which I may request or authorize. I understand that by signing below I acknowledge that I have received adequate information about the risks of common dental treatment. I have had all of my questions answered. I understand this form.

_____ I understand these risks and consequences and give my consent for treatment.

_____ I understand these risks and consequences and refuse to give my consent for treatment.

Patient Signature

Patient Name

Date

Dentist Signature

Witness Signature

Date