Las Vegas Dentistry, LLC
2421 W. Charleston Blvd. Las Vegas, NV. 89102
dentistoflasvegas.com 702-870-3818

Welcome to Las Vegas Dentistry

We're glad to have the opportunity to serve you. Please take a few minutes to fill out this form as completely as you can. If you have any questions, just ask, we'll gladly help you out.

PATIENT INFORMATION

Name_____ SS/Patient ID #_____ Date___/___/_____
Last Name First Name

Home Phone (___) _____ Mobile Phone (___)_____ Email_____

Address _____ City_____ State_____ Zip_____

Gender: ☐M ☐F Age: _____ Date of Birth ___/____/_____ ☐ Married ☐ Single ☐Minor (under 18)

Name of Emergency Contact_____ Phone (___) _____

Employer/School_____ Occupation_____

Employer/School Address_____ Phone (___)_____

Whom may we thank for referring you? _____

PRIMARY INSURANCE

Insurance Company_____

Contact #_____ Group #_____ Subscriber #_____

Person Responsible for Account_____
Last Name First Name Middle Initial

Date of Birth ____/____/_____ SS #_____ Relation to Patient_____

Address (if different from patient's)_____ City_____ State_____ Zip_____

Employer of Person Responsible_____ Occupation_____

Employer Address_____ Employer Phone (___)_____

Names of other dependents covered under this plan_____

ADDITIONAL INSURANCE

Insurance Company_____

Contact #_____ Group #_____ Subscriber #_____

Person Responsible for Account_____
Last Name First Name Middle Initial

Date of Birth ____/_____/_____ SS #_____ Relation to Patient_____

Address (if different from patient's)_____ City_____ State_____ Zip_____

Employer of Person Responsible_____ Employer Phone (____)_____

PATIENT DENTAL HISTORY

Reason for today's visit? _____

Previous Dentist_____

Date of last dental care: ____/____/_____ Date of last dental X-ray: ____/____/_____

How often do you brush? _____ How often do you floss? _____

Check (✓) if you have a problem with:

☐Bad Breath	☐Bleeding Gums	☐Broken filling	☐Chipped teeth	☐Clicking/Popping
☐Food stuck between	☐Grinding teeth	☐Loose teeth	☐Periodontal	☐Sensitivity - Biting
☐Sensitivity Cold	☐Sensitivity – Heat	☐Sensitivity – Sweets	☐Sores/growths in mouth	

AUTHORIZATION

I acknowledge that the information I have provided is correct to the best of my knowledge and that this information will be used and shared in relation to my, or my dependent's treatment. This information may be disclosed to the insurance company(ies) and/or to their agents for the purpose of determining insurance benefits, benefits payable for related services, and for obtaining payment. I certify that I, and/or my dependent(s) have dental insurance with _____. I authorize Las Vegas Dentistry, LLC (doctor(s) and staff) to take x-rays, photographs, and any other diagnostic aids needed for diagnosis and treatment.

I understand that full payment is due at time of treatment and I am the person financially responsible for total payment of the services provided regardless of the amount paid by my insurance. I authorize the assignment of all insurance benefits directly to Las Vegas Dentistry, LLC that are otherwise payable to me for services rendered. I authorize the use of my signature on all insurance submissions.

_____ _____
Print name of Patient, Parent, Guardian, or Personal Representative Relation to Patient

_____ _____
Signature of Patient, Parent, Guardian, or Personal Representative Date