New Patient Registration

Hi-Tech Dental Care & OnCall Dental LV ♦ 6265 S. Rainbow Blvd. ♦ Las Vegas, NV 89118 ♦ 702-233-5551 ♦ www.lasvegassedation.com

Dr. Kayla Mai, DDS ♦ Dr. William Liu, DDS ♦ And Associates

Patient Name: ______________________ ***I prefer to be called***: ______________ ***Birthdate***: ______________

Male ☐ ***Female*** ☐ ***SS#***: ________-______-__________ ***Cell Phone***: (_____) ______-________ ***Other Phone***: (_____) ______-________

Home Address: ____ ***Zip Code***: __________

Email Address: ______________________________ ***Whom may we thank for referring you?*** ______________________

Do you have any conditions that would require a medical release from your Primary Care Physician? Yes ☐ No ☐

What is your preferred method of communication? Text ☐ Phone ☐ Email ☐ Direct Mail ☐ ***Do we have permission to email/text you?*** Yes ☐ No ☐

Emergency Contact: ______________________ ***Relationship***: ______________ ***Contact Phone #***: (_____) ______-________

Marital Status: Single ☐ Married ☐ Child ☐ Other ☐ ______________

Is this patient covered by insurance? Yes ☐ No ☐ ***Group #:*** ______________ ***Insurance Company***: ______________________

Subscriber's Name: ______________________ ***Patient's relationship to Subscriber***: Self ☐ Spouse ☐ Child ☐ Other ☐ __________

Subscriber's Employer: ______________________ ***Subscriber's DOB***: ______________ ***Subscriber's SS#***: ______-_____-________

Does this patient have secondary insurance? Yes ☐ No ☐ ***Insurance Company***: ________________________________

Subscriber's Name: ______________________ ***Patient's relationship to Subscriber***: Self ☐ Spouse ☐ Child ☐ Other ☐ __________

Subscriber's Employer: ______________________ ***Subscriber's DOB***: ______________ ***Subscriber's SS#***: ______-_____-________

Are you having any dental problems? Yes ☐ No ☐

What are your concerns? (Check all that apply)

☐ Pain Avoidance ☐ Appearance ☐ Losing Teeth ☐ Gum/Periodontal Disease/Cleaning ☐ Cavities
☐ Insurance/Finances ☐ Routine Checkup ☐ Your General Health ☐ Other ______________

Please answer the following questions:

1. Are you presently under the care of a physician? Yes ☐ No ☐
2. Have you ever had high blood pressure? Yes ☐ No ☐
3. Has a physician ever said you have heart trouble? Yes ☐ No ☐
4. Do you have mitral valve prolapse? Yes ☐ No ☐
5. Do you have artificial joints? Yes ☐ No ☐
6. Have you ever had abnormal bleeding following a cut or extraction? Yes ☐ No ☐
7. Has a physician or dentist ever said you had a tumor or cancer? Yes ☐ No ☐
8. Are you allergic to Penicillin, Novacain, Codeine, or any other medicine? Yes ☐ No ☐
   If other, please list: ______________________
9. Are you allergic to anything other than medicine? (E.g. latex, metals, etc.) Yes ☐ No ☐
   If other, please list: ______________________
10. Have you ever been told you need antibiotics prior to dental treatment? Yes ☐ No ☐

Are you now taking?

1. Drugs for high blood pressure? Yes ☐ No ☐
2. Drugs for sleep? Yes ☐ No ☐
3. Cortisone, steroids, or ACTH? Yes ☐ No ☐
4. Anticoagulants or blood thinner? Yes ☐ No ☐
5. Tranquilizers or sedatives? Yes ☐ No ☐
6. Antibiotics? Yes ☐ No ☐
7. Insulin? Yes ☐ No ☐
8. Please list all medications you are currently taking:
   ____
   ____
   ____

Do you have or have you ever had?

1. Rheumatic fever? Yes ☐ No ☐
2. Heart disease or pacemaker? Yes ☐ No ☐
3. Anemia, leukemia, or low platelets? Yes ☐ No ☐
4. Epilepsy or convulsions? Yes ☐ No ☐
5. Asthma or hay fever? Yes ☐ No ☐
6. Tuberculosis? Yes ☐ No ☐
7. Diabetes? How long? Yes ☐ No ☐
8. Kidney trouble? Yes ☐ No ☐
9. Liver trouble or jaundice? Yes ☐ No ☐
10. Thyroid trouble or goiter? Yes ☐ No ☐
11. Syphilis? Yes ☐ No ☐
12. Fainting or dizziness? Yes ☐ No ☐
13. Glaucoma? Yes ☐ No ☐
14. Arthritis? Yes ☐ No ☐
15. HIV/AIDS? Yes ☐ No ☐
16. Stroke? Yes ☐ No ☐
17. Stomach ulcer? Yes ☐ No ☐
18. Heart murmur? Yes ☐ No ☐
19. Prostate trouble? Yes ☐ No ☐
20. Hepatitis? Yes ☐ No ☐
21. Eczema or hives? Yes ☐ No ☐
22. Psychiatric treatment? Yes ☐ No ☐
23. Are you pregnant? Yes ☐ No ☐

- I understand that payment is due at time of scheduling. I will pay today by: Cash ☐ Check ☐ Credit Card ☐
- I verify that all preceding information is true. I authorize the release of information to my insurance company. I will allow Hi-Tech Dental and Sedation Dental Care and their associates to discuss my conditions with my physician(s) and to request medical information from them.
- I authorize Hi-Tech & Sedation Dental Care to obtain and verify a credit report. I also acknowledge that I have been given or offered a copy of the office's "Notice of Privacy Practices."
- I understand that any inbound or outbound calls made to or from this office may be recorded for quality and training purposes.

Signature: ________________________________ ***Date***: ______________