Patient Information

Jake H. Banks, D.D.S
Robert E. Mays, Jr., D.D.S.

Date_____

*Patient Name_____ DOB_____/_____/_____ Age_____

Address_____ Own____ Rent____ S.S.N._____/_____/_____

City/St_____ Zip Code_____ Telephone_____ Cell_____

Your Employer_____ Telephone_____ Ext_____

E-mail_____

*Name of Spouse_____ S.S.N_____/_____/____DOB____/____/_____

Spouses Employer_____ Telephone_____ Ext_____

*Name of Responsible Party (if other than patient)_____

Address_____ Own____Rent____ S.S.N._____/_____/_____

City/St_____ Zip Code_____Telephone_____

In case of emergency_____ Telephone_____

Nearest relative not living with you _____

Address_____ Telephone_____

*Who may we thank for referring you to our office?_____

Dental Insurance Information

Primary Insurance Name	Address(street-city-state-zip)	Telephone
_____	_____	_____

Name of Insured	Relationship	S.S.N.	Group #
_____	_____	_____/_____/_____	_____

Secondary Insurance Name	Address (street-city-state-zip)	Telephone
_____	_____	_____

Name of Insured	Relationship	S.S.N.	Group #
_____	_____	_____/_____/_____	_____

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I Understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the record of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and / or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment or co-payment is due on the day of service.

X_____ _____

Signature of Patient (or Parent If Minor) *Date*

Dental History

Jake H. Banks, D.D.S., APC
Robert E. Mays, Jr., D.D.S.

Patient Name_____D.O.B._____

Purpose of visit_____

How long since your last comprehensive dental exam?_____

What type of dental treatment did you last receive?_____

Previous dentist's name?_____

When was your last hygiene visit?_____

Have you made regular dental visits?_____

How often?_____

Were dental x-rays taken, if yes how long ago?_____

Have you lost any teeth?_____

If so, have they been replaced? Yes_____ No_____

What type of replacement?_____

Have you ever had any complications with previous dental work?_____

If yes, what?_____

Do you clench or grind your teeth?_____

Do you ever wake up with headaches?_____

Does food get caught between your teeth?_____

Are your teeth sensitive to hot____ cold____ sweets____ pressure____

Do your gums bleed when you brush or floss?_____

Have you ever had gum treatment or gum surgery?_____

Are you unhappy with the appearance of your teeth?_____

Do any of your teeth feel loose?_____

Have you had any past dental experiences that have made you fearful of dentists?-

_____

_____ _____

Signature of Patient (or parent if minor) Date

Eaglesoft Medical History

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	◯ Yes ◯ No	If yes
Have you ever been hospitalized or had a major operation?	◯ Yes ◯ No	If yes
Have you ever had a serious head or neck injury?	◯ Yes ◯ No	If yes
Are you taking any medications, pills, or drugs?	◯ Yes ◯ No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	◯ Yes ◯ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	◯ Yes ◯ No	If yes
Are you on a special diet?	◯ Yes ◯ No	
Do you use tobacco?	◯ Yes ◯ No	
Do you use controlled substances?	◯ Yes ◯ No	If yes

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Acrylic
☐ Metal	☐ Latex	☐ Sulfa Drugs	☐ Local Anesthetics

Other? ☐ If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive ◯ Yes ◯ No	Cortisone Medicine ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	High Cholesterol ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Breathing Problems ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Genital Herpes ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Osteoporosis ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Pacemaker ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Convulsions ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No
			Yellow Jaundice ◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X _____ Date: _____

Financial Policy for the Office of
Jake H. Banks, D.D.S. APC
Robert E. Mays, Jr., D.D.S.

In the interest of good health care practice, it is desirable to establish a credit policy to avoid misunderstandings. Our primary responsibility is to help our patients experience good health and we wish to spend our time and energy toward that end.

* All accounts are due and payable at the time of your visit, unless satisfactory arrangements have been made with our Office Administrator. For those without insurance, there will be a 10% discount for amounts paid in full on the day of service by cash or check. There will be a 5% discount for amounts paid in full with any major credit card including debit cards. We accept Visa, MasterCard, Discover, American Express and Care Credit.

* On accounts which have established arrangements, payment is due upon receipt of the monthly statement. Any balance outstanding more than 60 days will bear interest at 18% per year or 1.5% per month. Also, a $35.00 fee will be added to any account that is sent to collections.

* Insurance is gladly billed as a courtesy to our patients when you provide us with current information and any necessary forms. Even though you may have an insurance claim pending, you will receive a monthly statement for the outstanding balance of your account. We cannot accept responsibility for collecting an insurance claim after 60 days or for negotiating a disputed claim. Insurance reimbursement is a contract between you, your employer and the insurance carrier. YOU are responsible for the payment of your account.

*** There will be a $40 minimum charge for any cancelled or broken appointment without a TWO BUSINESS DAY NOTICE.** The length of time scheduled for you determines the charge. We will not reschedule any patient after appointments have been missed. Our time must be used as efficiently as possible to keep our expenses at a minimum and our fees within reasonable limits.

*Upon scheduling any 2 hour hygiene appointment, a minimum deposit of $75.00 will be collected. We require a 3 business day cancellation notice, otherwise you will forfeit your deposit.

Initials _____

I have read this credit policy and understand that regardless of any insurance coverage I may have, I am responsible for payment of my account. I understand that delinquent accounts will be assigned to a credit reporting collection service. If it becomes necessary to effect collections of any amount owed on this or subsequent visits, the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees. This will ensure that our responsible patients will not be penalized to cover costs incurred by those who do not pay on time.

Signature _____Date _____

ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES

Jake H. Banks, D.D.S., APC
Robert E. Mays, Jr., D.D.S.

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 acknowledgement of Receipt of our Notice of Privacy Practices was attempted, however acknowledgement could not be obtained because:

() Individual refused to sign

() Communication barriers prohibited obtaining the acknowledgement

() An emergency situation prevented us from obtaining acknowledgement

() Other_____

_____

_____

NOTICE OF PRIVACY PRACTICES
Jake Banks, D.D.S. APC
Robert E. Mays, Jr., D.D.S.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

If you have any questions about this Notice please contact: our Privacy Contact who is Jake H. Banks, D.D.S.

This Notice describes your rights as a patient to access and control your medical records also known as protected health information or PHI. This notice also describes our privacy practices and legal duties concerning how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by both state and federal law. Our office and staff will follow the privacy practices that are described in this Notice while it is in effect. When new regulations are created, we will update this Notice. This Notice takes effect April 14, 2003, and will remain in effect until we replace it.

Upon your request, we will provide you with any revised Notice of Privacy Practices by either calling this office or asking for one at the time of your next appointment. You may request a copy of our Notice at any time.

Uses and Disclosures of Protected Health Information

Your protected health information may be used for treatment, payment, and healthcare operations. The following are examples of the uses and disclosures.

Treatment: We will use and disclose your protected health information to a physician or other healthcare entity providing treatment to you. For example; we may provide your protected health information to a physician with whom you have been referred to in order to diagnose or treat you.

Payment: We may use and disclose your protected health information as needed, to obtain payment for your health care services. For example; we may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services rendered.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in connection with our healthcare operations. This may include quality assessment activities, employee review activities and training , certification, accreditation, and licensing. For example; we may call you by name in the waiting room when your physician is ready to see you and we may contact you to remind you if your appointment.

Aside from using and disclosing your protected health information for Treatment, Payment, or Healthcare Operations, you may give us **Authorization** to use or disclose your health information to anyone for any purposes. At anytime in writing, you may revoke your authorization. If you don't give us **Authorization,** we cannot use or disclose your protected health information for any other reason except for treatment, payment, and healthcare operations.

Family and Friends: If you agree, we may disclose your protected health information to a family member, friend or other person to the extent the Privacy Rule, defined in this Notice.

Other Persons Involved In Care: Unless you object, we may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Additionally, using our professional judgement, we may allow a person to pick up your filled prescription(s), medical supplies, x-rays or other similar forms of health information. In case of an emergency, we may use or disclose your protected health information that is directly relevant to the person's involvement in your healthcare.

Marketing: Our office will not use your protected health information for marketing purposes without your prior written authorization except for a face-to-face encounter or a communication involving a promotional gift of nominal value.

The Law: Our office will use or disclose your protected health information if and when either state or federal law requires it. If requested, you will be notified of any such uses or disclosures.

Other Uses or Disclosures of Your Protected Health Information: If we reasonably believe that you are a victim of abuse, neglect, domestic violence, or other crimes, we may disclose your protected health information to the proper authorities. We may disclose your protected health information for **public health activities** and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. We may disclose your protected health information to comply with **workers' compensation laws** and other similar legally-established programs. We may disclose your health information to military authorities of the **Armed Forces** if applicable. We may also disclose your protected health information to authorized federal officials for conducting **national security**, and **intelligence activities.** We may also disclose protected health information if it is necessary for **law enforcement authorities** to identify or apprehend an individual, or in response to subpoena, discovery request or other lawful process. We may also disclose your protected health information to **researchers** when an institutional review board has approved their research. We may also use or disclose your health information to provide you with you with **appointment reminders**.

Your Individual Rights

Access: By written request you have the right to **inspect** or **receive a copy** of your protected health information in part or in full. We may charge you $25.00 flat rate per hour for staff time plus any postage fee if applicable. If you request an alternative format for copies, we will charge you a reasonable cost-based fee for providing your health information in that format. Please feel free to contact us using the information listed at the end of this notice for a full explanation of our fee structure.

Under federal law, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewed.

Amendment: You have the right to request an amendment of your protected health information. This request must be in writing and must explain the reason for such an amendment. We may deny your request under certain circumstances.

Disclosure Accounting: You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information, other than for treatment, payment, and healthcare operations. You have the right to receive specific information regarding these disclosures for up to 6 years that occurred after April 14, 2003.

Restrictions: You have the right to request restrictions on certain uses or disclosures of your protected health information, however, we are not required to agree to a restriction that you may request. If we do agree to your request, we will abide by our agreement unless of an emergency.

Alternative Communication/Location: By written request, you have the right to receive confidential communications from us by alternative means or at an alternative location. We will not request an explanation from you as to the basic for the request, however, we may condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact.

Electronic Notice: If you agree to receive this Notice electronically, you may also request a paper copy.

Complaints: If you believe that your privacy rights have been violated, you may file a written complaint with either our office by using the contact information listed below, or with the U.S. Department of Health and Human Services. If you do choose to file a complaint, we will not retaliate in any way.

We support your right to the privacy of your health information. If you would like more information about our privacy practices or have questions or concerns please feel free to contact us.

Contact/ Privacy Officer- Dodie @ Jake Banks D.D.S.
Telephone: 775-358-0147 Fax: 775-358-5701

E-mail N/A

Address: 2261 Pyramid Way Suite # 3 Sparks, NV 89431