Significance Dental Specialists
Periodontics Orthodontics Endodontics

Fabulous SuperStar Smiles- Same Day Braces & Invisalign- Guaranteed

Why Choose Significance Orthodontics?

- **Our Doctors are educators and leaders for the General Dentists in the Las Vegas community.**
- **Our Doctors have been featured on the covers of Las Vegas Women Magazine, and been voted for top dentists by their peers for consecutive years.**
- **We offer same day appointments and SAME DAY braces/Invisalign.**
- **Late evening and Saturday hours are available: Less missing school or work**
- **Options for replacement of up to four sets of retainers with no additional charges.**
- **Options for Life Time Warrantee for your fabulous smiles.**
- **We value your time! You are always seen on time.**
- **Yes, you can call Dr. Victoria's and Dr. Judy's cell phone anytime!**
- **Accelerated treatment options to shorten your treatment time less than a year.**
- **We send out bimonthly newsletters and weekly emails to keep you connected 24/7.**
- **Awesome referral and VIP programs so our patients can't stop talking about us!**
- **Fun patient contests, games, prizes and events for your best patient experience!**
- **We offer easy payment options to fit your budgets. You will be surprised how affordable braces and Invisalign are.**
- **We use the newest technology such as the 3D cone beam technology and intraoral scanner system. Less x-rays and messy impressions for you.**
- **Our staffs are friendly, knowledgeable and energetic! We have regular staff training to ensure our patients receive Six-Star patient experience during your visits! You will be pampered by us.**

significanceorthodontics.com

WELCOME

Patient Information

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

E-mail _____

City _____

State _____ Zip _____

Sex D M D F Birthdate _____ Age _____

D Married O Widowed D Single O Minor

D Separated D Divorced D Partnered for _____ years

Patient Employer/School _____

Occupation _____

Employer/School Address _____

_____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____

SS _____

Spouse's Employer _____

Whom may we thank for referring you? _____

Dental Insurance

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? D Yes D No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to
Name of Insurance Company(ies)

Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plans completed or one year from the date signed below.

Signature of Patient, or Parent. Guardian or Personal Representative

Please print name of Patient, Parent, Guardian or Personal Representative

Date Relationship to Patient

Phone Numbers

Phone (_____) _____ Work ( ) _____ Ext Alt. Phone (_____) _____

Spouse's Work (_____) _____ Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name Relationship

Phone (_____) _____ Work Phone (_____) _____

Dental History

Reason for today's visit _____

_____

Former Dentist _____

City/State

Date of last dental visit _____

Date of last dental X-rays

Place a mark on "yes" or "no" to indicate if you have had any of the following:

Bad breath	0Yes	O No
Bleeding gums	0Yes	O No
Blisters on lips or mouth	0Yes	O No
Burning sensation on tongue	O Yes	O No
Chew on one side of mouth	0Yes	0No
Cigarette, pipe, or cigar smoking	0Yes	0No
Clicking or popping jaw	0Yes	O No
Dry mouth	0Yes	O No
Fingernail biting	O Yes	O No
Food collection between the teeth	O Yes	0No
Foreign objects	O Yes	O No
Grinding teeth	0Yes	O No
Gums swollen or tender	0Yes	O No
Jaw pain or tiredness	0Yes	O No
Lip or cheek biting	0Yes	O No
Loose teeth or broken fillings	0Yes	O No
Mouth breathing	DYes	O No
Mouth pain, brushing	0Yes	O No
Orthodontic treatment	O Yes	O No
Pain around ear	0Yes	O No
Periodontal treatment	0Yes	O No
Sensitivity to cold	0Yes	O No
Sensitivity to heat	0Yes	O No
Sensitivity to sweets	O Yes	O No
Sensitivity when biting	O Yes	O No
Sores or growths in your mouth	0Yes	O No

How often do you floss? _____

How often do you brush? _____

Health History

Physician's Name _____ Date of last visit _____

Have you ever used a bisphosphonate medication? Common brand names are Fosamax, Actonel, Atelvia, Didronel, Boniva. D Yes D No

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). D Yes D No

Place a mark on "yes" or "no" to indicate if you have had any of the following:

AIDS/HIV	O Yes	O No	Epilepsy	O Yes	O No	Respiratory Disease	O Yes	O No			
Anemia	O Yes	O No	Fainting or dizziness	O Yes	O No	Rheumatic Fever	O Yes	O No			
Arthritis, Rheumatism	O Yes	O No	Glaucoma	O Yes	O No	Scarlet Fever	O Yes	O No			
Artificial Heart Valves	O Yes	O No	Headaches	O Yes	O No	Shortness of Breath	O Yes	O No			
Artificial Joints	O Yes	O No	Heart Murmur	O Yes	O No	Sinus Trouble	O Yes	O No			
Asthma	O Yes	O No	Heart Problems	O Yes	O No	Skin Rash	O Yes	O No			
Back Problems	O Yes	O No	Hepatitis Type	O Yes	O No	Special Diet	O Yes	O No			
Bleeding abnormally, with extractions or surgery	D Yes	O No	Herpes	O Yes	O No	Stroke	O Yes	O No			
Blood Disease	O Yes	O No	High Blood Pressure	O Yes	O No	Swollen Feet or Ankles	O Yes	O No			
Cancer	O Yes	O No	Jaundice	O Yes	O No	Swollen Neck Glands	O Yes	O No			
Chemical Dependency	O Yes	O No	Jaw Pain	O Yes	O No	Thyroid Problems	O Yes	O No			
Chemotherapy	O Yes	O No	Kidney Disease	O Yes	O No	Tonsillitis	O Yes	O No			
Circulatory Problems	O Yes	O No	Liver Disease	O Yes	O No	Tuberculosis	O Yes	O No			
Congenital Heart Lesions	O Yes	O No	Low Blood Pressure	O Yes	O No	Tumor or growth on head or neck	O Yes	O No			
Cortisone Treatments	O Yes	O No	Mitral Valve Prolapse	O Yes	O No	Ulcer	O Yes	O No			
Cough, persistent or bloody	O Yes	O No	Nervous Problems	O Yes	O No	Venereal Disease	O Yes	O No			
Diabetes	O Yes	O No	Pacemaker	O Yes	O No	Weight Loss, unexplained	O Yes	O No			
Emphysema	O Yes	O No	Psychiatric Care	O Yes	O No						
			Radiation Treatment	O Yes	O No						

Do you wear contact lenses? O Yes O No

Women:

Are you pregnant? O Yes O No Due date _____ Are you nursing? D Yes O No

Taking birth control pills? O Yes O No

Medications

List any medications you are currently taking and the correlating diagnosis:

_____

_____

_____

Pharmacy Name _____

Phone (___) _____

Allergies

D Aspirin D Local Anesthetic

D Barbiturates (Sleeping pills) D Penicillin

D Codeine O Sulfa

D Iodine D Other _____

D Latex _____

Updates (To be filled in at future appointments)

Has there been any change in your health since your last dental appointment? D Yes C No

For what conditions? _____

Are you taking any new medications? _____ If so, what? _____

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

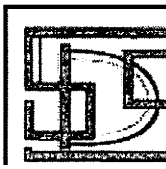
Has there been any change in your health since your last dental appointment? D Yes D No

For what conditions? _____

Are you taking any new medications? _____ If so, what? _____

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____



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ACKNOWLEDGEM ENT OF RECEIPTOF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowledgement*

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

Please Print Name

Signature

Date

For Office Use Only

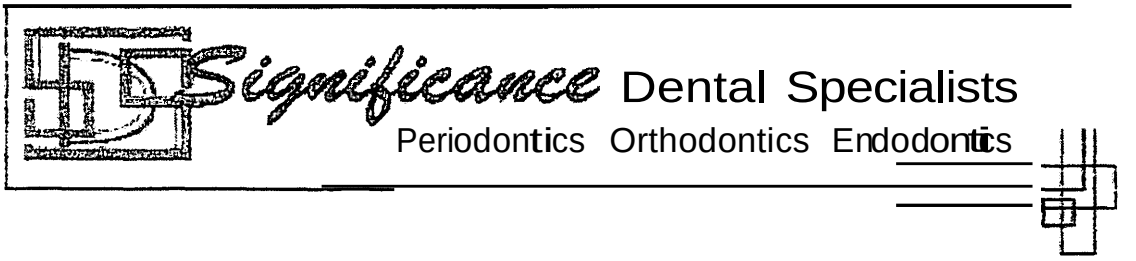
We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

CJ Individual refused to sign

a Communications barriers prohibited obtaining the acknowledgment a

An emergency situation prevented us from obtaining acknowledment a

Other (Please Specify)



NOTICE OFPRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USEDAND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW ITCAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices. Our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change In our privacy practices, we will change this Notice and make the new Notice available upon request

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment. and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations. you may give us written authorization to use your health infonnation or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at anytime. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify. or assist in the notification of (including Identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your

health information, we will provide you with an opportunity to object to such uses or disclosures. Inthe event of your incapacity or emergency circumstances. we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x• rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities ifwe reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your healthor safety or the health or safety of others.

National Security: We may disclose to military authorities the health Information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful Intelligence, counterintelligence, and other national security activities. We may dtsclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (suchasvoicemailmessages. postcards. orletters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies ina format other than photocopies. Wewill use the format you request unless we cannot practicably do so. (You must make a request inwriting to obtain access to your health information. You may obtain a form to request access by usingthe contad information fisted at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies andstaff time. You may also request access by sendingus a letter to the address at the end of this Notice. Ifyou request copies, we will charge you $__ for each page, $__ per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. Ifyou request an alternative format, we will charge acost-based fee for providingyour health information inthat format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us usingthe information listed at the end ofthis Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment. payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once ina 12-monthperiod, we maycharge youa reasonable, cost-based fee for respondingto theseadditional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but Ifwe do, we will abide by our agreement (exceptinanemergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. {You must make your request Inwriting.} Your request must specify the alternative means or location. and provide satisfactory explanation how payments will be handled under the alternative meansorlocationyou request.

Amendment: You have the right to request that we amend your health information. (Your request must be inwriting, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: Ifyou receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice inwritten form.

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CONSENT TO EXAMINE PATIENT

It may be necessary to take diagnostic x-rays in order to determine an appropriate treatment plan and patient diagnosis.

I hereby authorize the attending doctor and/or staff to examine me and to take these diagnostic x-rays, if necessary, and prepare an orthodontic treatment evaluation.

Insurance Policies

Dental insurance is great! We will gladly help fill out all those complicated forms. We are in-network providers for most of the insurances, and we can work with most insurance PPO and HMO providers to help you get the most out of your insurance benefits. Our office insurance expert will evaluate your insurance plan and work to get you the maximum reimbursement. Remember that you are ultimately responsible for your account. **Insurance is a contract between you and your insurance company. We process the paperwork and make our recommendations. The insurance company decides what they will pay.** Please be aware that some or all of the treatments we have recommended for your smile restoration and health enhancement may be considered non-covered or not reasonable or necessary under your insurance program.

_____

Signature of Patient (or Guardian) Date

_____

Printed Name of Patient (or Guardian)

VICTORIA CHEN, DDS, MS
SIGNIFICANCE ORTHODONTICS
2777 W. Craig Road, Suite 101, N. Las Vegas, NV 89032
6018 S. Fort Apache Rd. #100 Las Vegas, NV 89148
2430 E Harmon Ave., #6 Las Vegas, NV 89121

Permission to Use Photograph

Name of Patient: _____

Here at Significance Dental Specialists we take photos of our patients for spirit week, holidays, silly fun photos when we take our patients braces off and we would like your permission to share these on our Facebook or website.

□ I grant to Significance Dental Specialists, its representatives and employees the right to take photographs of (patient named above).

□ I authorize Significance Dental Specialists, its assigns and transferees to copyright, use and publish the same in print and/or electronically.

□ I agree that Significance Dental Specialists may use such photographs of patient named above with or without my name and for any lawful purpose, including for example such purposes as publicity, illustration, advertising, and Web content.

□ I prefer not to participate.

Signature _____

Printed name _____

Date _____