Marielaina Perrone

LOVE YOUR DENTIST ♥ LOVE YOUR TEETH ♥ LOVE YOUR SMILE

Dear Patient,

Thank you for choosing our practice. I sincerely appreciate the opportunity to care for your smile.

My philosophy is simple—to provide exceptional dentistry in a welcoming, comfortable environment where every patient feels heard, respected, and genuinely cared for.

Whether you are visiting us for preventive care, cosmetic dentistry, dental implants, or facial aesthetics, every recommendation we make is based on your individual needs, your goals, and your long-term oral health.

Please take a few moments to complete the enclosed forms before your appointment whenever possible. Doing so allows our team to prepare for your visit and spend more time getting to know you and discussing your dental health and smile goals.

If you have any questions before your appointment, please don't hesitate to contact our office. We are always happy to help.

Thank you again for placing your trust in us. We look forward to welcoming you personally and helping you enjoy a lifetime of healthy, confident smiles.

I look forward to meeting you personally.

Marielaina Perrone

Marielaina Perrone, DDS

2551 N. Green Valley Parkway, Suite A-405
Henderson, Nevada 89014

(702) 458-2929

drperrone.com

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NEW PATIENT INFORMATION FORM

1 PATIENT INFORMATION

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name First Name Middle Initial

Preferred Name _____

Address _____

City _____ State _____ Zip _____

Cell Phone _____ Home Phone _____

Email _____

Date of Birth _____ Age _____

Sex ☐ Male ☐ Female ☐ Non-Binary

Marital Status ☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Occupation _____

Employer/School _____

Employer/School Address _____

_____

Employer/School Phone (_____) _____

Spouse's Name _____

Spouse's Employer _____

Whom may we thank for referring you? _____

2 DENTAL INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ 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

_____
Name of Insurance Company(ies)

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 plan is completed or one year from the date signed below.

_____
Signature of Patient, Parent, Guardian or Personal Representative

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

_____ _____
Date Relationship to Patient

3 PHONE NUMBERS

Phone (_____) _____ Work (_____) _____ Ext _____ Cell (_____) _____

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 _____

Home Phone (_____) _____ Work Phone (_____) _____

4 DENTAL HISTORY

Reason for today's visit _____

Burning sensation on tongue	☐ Yes	☐ No	Gums swollen or tender	☐ Yes	☐ No	Sensitivity to cold	☐ Yes	☐ No
Chew on one side of mouth	☐ Yes	☐ No	Jaw pain or tiredness	☐ Yes	☐ No	Sensitivity to heat	☐ Yes	☐ No
Cigarette, pipe, or cigar smoking	☐ Yes	☐ No	Lip or cheek biting	☐ Yes	☐ No	Sensitivity to sweets	☐ Yes	☐ No
Clicking or popping jaw	☐ Yes	☐ No	Loose teeth or broken fillings	☐ Yes	☐ No	Sensitivity when biting	☐ Yes	☐ No
Dry mouth	☐ Yes	☐ No	Mouth breathing	☐ Yes	☐ No	Sores or growths in your mouth	☐ Yes	☐ No
Fingernail biting	☐ Yes	☐ No	Mouth pain, brushing	☐ Yes	☐ No			
Food collection between the teeth	☐ Yes	☐ No	Orthodontic treatment	☐ Yes	☐ No	How often do you floss? _____		
Foreign objects	☐ Yes	☐ No	Pain around ear	☐ Yes	☐ No			
Grinding teeth	☐ Yes	☐ No	Periodontal treatment	☐ Yes	☐ No	How often do you brush? _____		

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	☐ Yes	☐ No	Mouth sores	☐ Yes	☐ No
Bleeding gums	☐ Yes	☐ No	Swollen glands	☐ Yes	☐ No
Blisters on lips or mouth	☐ Yes	☐ No	Unexplained weight loss	☐ Yes	☐ No

thank you

WE LOOK FORWARD TO PROVIDING YOU WITH EXCEPTIONAL CARE.

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HEALTH HISTORY

Please complete to the best of your ability.

5 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. ☐ Yes ☐ No

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

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

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

Do you wear contact lenses? ☐ Yes ☐ No

Women:

Are you pregnant? ☐ Yes ☐ No Due date _____ Are you nursing? ☐ Yes ☐ No

Taking birth control pills? ☐ Yes ☐ No

MEDICATIONS

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

_____

_____

_____

Pharmacy Name _____

Phone (_____) _____

ALLERGIES

☐ Aspirin ☐ Local Anesthetic

☐ Barbiturates (Sleeping pills) ☐ Penicillin

☐ Codeine ☐ Sulfa

☐ Iodine ☐ Other _____

☐ Latex _____

6 UPDATES (To be filled in at future appointments)

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

For what conditions? _____

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

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

thank you

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NOTICE OF PRIVACY PRACTICES ACKNOWLDGEMENT

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

Treatment Coordination: To plan, conduct, and direct your treatment and follow-up care among various healthcare providers and laboratories involved in your direct or indirect care.

Billing and Payment: To obtain payment from third-party administrators.

Healthcare Operations: To conduct standard operations, including quality assessments and physician certifications.

Record Requests: To request dental records and x-rays from your previous providers.

SMS Communication: We use your provided mobile number to send text messages for appointment confirmations, cost breakdowns for dental work, and requests for insurance information or identification photos.

Email Communication: We use email to securely send x-rays and referrals to dental specialists.

I understand that I may request a comprehensive copy of your *Notice of Privacy Practices*, which contains a more complete description of the uses and disclosures of my health information. I also understand that your organization reserves the right to change its *Notice of Privacy Practices* periodically, and that I may contact you at any time at the address below to obtain a current copy.

I understand that I have the right to request, in writing, a restriction on how my private health information is used or disclosed for treatment, payment, or healthcare operations. I also understand that Dr. Perrone is not required to agree to my requested restrictions; however, if the request is accepted, I understand that the practice is then bound to abide by those specific restrictions.

I have been informed by you of your *Notice of Privacy Practices*, which contains a more complete description of the uses and disclosures of my health information. I understand that I have the right to review such Notice of Privacy Practices prior to signing this consent.

LIST INDIVIDUALS WHO CAN HAVE ACCESS TO YOUR DENTAL INFORMATION:

Name / Relationship: _____ Phone: _____

Name / Relationship: _____ Phone: _____

PRINT Patient Name: _____ Date: _____

SIGNATURE Self / Guardian: _____ Date: _____

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FINANCIAL POLICY AGREEMENT

Thank you for choosing Marielaina Perrone DDS. Our primary mission is to deliver the highest quality, most comprehensive dental care available. To support this mission, we strive to make the cost of optimal care as manageable as possible for our patients. We are pleased to offer several payment options to help you achieve your oral health goals.

PAYMENT OPTIONS

We offer several payment options for your convenience, including American Express, VISA, Mastercard, Discover, cash, and debit cards.

Additionally, no-interest payment plans are available through CareCredit. You can find more information at www.carecredit.com or ask us for assistance with the application process.

CARECREDIT

- **Interest-free* payment plans** are available to allow you to pay over time.**
- **Convenient, low monthly payment options are offered.**
- **There are no annual fees or pre-payment penalties.**

Please note that Marielaina Perrone DDS requires payment prior to the completion of your treatment. If you choose to discontinue care before treatment is complete and lab work has been initiated, a full refund will not be issued.

For patients with dental insurance, we are happy to work with your carrier to maximize your benefits and bill them directly for your treatment*** coverage/reimbursement.

APPOINTMENTS AND PAYMENTS

Please be advised of our office policies regarding appointments and payments:

- **Cancellations:** A fee of $50 per hour will be charged for appointments missed or canceled without at least 24 hours' notice.
- **Returned Checks:** A $50.00 fee applies to all returned checks.
- **Communication:** By providing your contact information, you agree that we may reach out to you via landline or cell phone/text regarding your account and scheduled appointments.

If you have any questions, please do not hesitate to ask. We are here to help you receive the dental care you deserve.

Please be advised that any accounts sent to a collection agency due to non-payment of an outstanding balance will be subject to an additional 55% collection fee.

PRINT NAME _____ DATE _____

SIGNATURE _____

*If paid within promotional period. Otherwise, interest assessed from purchase date. Minimum monthly payment required.

**Subject to credit approval.

***However, if we do not receive payment from your insurance carrier within 30 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.

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DENTAL INSURANCE COVERAGE

It is your responsibility to update us on any changes to your dental insurance coverage prior to your scheduled appointments. Perrone Dental cannot track changes to insurance carriers or policies without updated information provided by the patient. To ensure we can bill for your services accurately, please provide any new insurance details before any scheduled appointment.

Your dental insurance is a contract between you, your employer, and the insurance carrier; Dr. Perrone is NOT a party to that contract. As such, dental benefits are not guaranteed and are subject to specific limitations, provisions, and exclusions. Dr. Perrone is NOT a contracted provider with any dental insurance company.

If your plan includes out-of-network coverage, we are happy to bill your insurance on your behalf. However, if you do not have out-of-network benefits, please be aware that your insurance will not cover any costs or fees at Perrone Dental.

While we strive to provide accurate estimates based on the information provided/available, insurance companies determine final payments only after a claim is received. Quotes provided via phone, fax, or pre-authorization are not guarantees of payment. Please note that because Dr. Perrone is NOT a contracted provider with any insurance company, carriers often do not disclose their specific fee schedules until a claim is processed. Consequently, when a carrier states they cover "100%" of a fee, this may refer to their own internal fee schedule rather than our office's actual fees.

It is your responsibility to understand the specifics of your coverage. Because there are numerous individual policies, we recommend contacting your Human Resources department or your dental insurance provider directly to confirm your exact benefits. Insurance companies are typically more responsive to policyholders regarding premium-related inquiries and plan details.

DUAL INSURANCE COVERAGE

Please be advised that if you have dual insurance coverage, it is your responsibility to notify us and coordinate benefits between both of your dental insurance providers. Perrone Dental is legally unable to coordinate benefits on your behalf. It is essential that this coordination is completed in a timely manner. Without updated information from both policies, we cannot accurately bill for your services. Furthermore, because each insurance company has strict time limits for claim submissions, failure to coordinate benefits promptly may lead to the following:

- **OVERPAYMENT:** Both companies may pay for the same service, leading to a request for a refund and leaving you responsible for the remaining balance.
- **CLAIM DENIALS:** Both companies may deny your claims entirely, resulting in you being responsible for the full cost of treatment.

Please contact your insurance providers as soon as possible to ensure your accounts are properly linked.

Our primary concern is your dental health, which may not always align with the coverage limitations set by your insurance provider. We appreciate your understanding and are happy to assist you in navigating your benefits as much as possible.

SIGNATURE Self/Guardian _____ **DATE** _____

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