New Patient Information

We are committed to excellence in dentistry and appreciate you taking the time to complete this confidential questionnaire. The better we communicate, the better we can care for you. If you have any questions or need help, please ask! We will be happy to help!

Whom may we thank for referring you? _____

About You

Name: _____I prefer to be called_____ Sex: ☐ M ☐ F

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widow ☐ Separated

Date of Birth: _____ Age: _____ Soc. Sec. No. _____

Address: _____ City: _____ State: ____ Zip: _____

Home Phone:_____ Work Phone: _____Ext. _____

Cell Phone: _____ E-Mail Address: _____

Employer: _____ How long there?: _____ Occupation: _____

Employer's Address: _____ City: _____ State: ____ Zip: _____

Person Responsible for Account

☐ Same as above

Name: _____ Birthdate: _____ Relation: _____

Billing Address: _____ City: _____ State: ____ Zip: _____

Home Phone: _____ Work Phone: _____ ext. _____

Employer: _____ How long there?: _____ Occupation: _____

Soc. Sec. No. _____

Spouse Information

☐ Same as above

Name: _____ Birthdate: _____

Employer: _____ Work Phone: _____ ext._____

Soc. Sec. No. _____

Dental Insurance Information

Primary Insurance

Insurance Co. Name: _____ Phone: _____ Group/Policy No. _____

Insured's Name: _____ Insured's Birth Date: _____ Relation: _____

Insured's Soc. Sec. No. / ID#_____Insured's Employer: _____

Home Address (If Different): _____

Secondary Insurance

Insurance Co. Name: _____ Phone: _____ Group/Policy No. _____

Insured's Name: _____ Insured's Birth Date: _____ Relation: _____

Insured's Soc. Sec. No. / ID#_____Insured's Employer: _____

Home Address (If Different): _____

Confidential Health History

I. GENERAL QUESTIONS

Circle Appropriate Answer – *Leave Blank if you do **not** understand the question*

1. Yes / No Is your general health good?

   If NO, explain: _____

2. Yes / No Has there been a change in your health within the last year?

   If YES, explain: _____

3. Yes / No Have you gone to the hospital, emergency room or had a serious illness in the last three years?

   If YES, explain: _____

4. Yes / No Are you being treated by a physician now?

   If YES, explain: _____

   Date of Last Exam & Reason: _____

5. Yes / No Have you had problems with prior dental treatment?

   If YES, explain: _____

   Date of Last Exam: _____ Name of Previous Dentist_____

6. Yes / No Are you in pain now?

   If YES, explain: _____

II. HAVE YOU EXPERIENCED ANY OF THE FOLLOWING? (Please circle Yes or No for each)

Yes / No	Chest Pain	Yes / No	Blood In Stools	Yes / No	Frequent vomiting
Yes / No	Fainting	Yes / No	Easily Bruise	Yes / No	Diarrhea/Constipation
Yes / No	Jaundice	Yes / No	Recent Weight Loss	Yes / No	Frequent urination
Yes / No	Dry Mouth	Yes / No	Fever	Yes / No	Difficulty urinating
Yes / No	Excessive thirst	Yes / No	Night Sweats	Yes / No	Ringing in Ears
Yes / No	Difficulty Swallowing	Yes / No	Persistent Cough	Yes / No	Headaches
Yes / No	Swollen Ankles	Yes / No	Coughing up Blood	Yes / No	Dizziness
Yes / No	Joint Pain/Stiffness	Yes / No	Bleeding Problems	Yes / No	Blurred Vision
Yes / No	Shortness of Breath	Yes / No	Blood in Urine	Yes / No	Sinus problems

III. HAVE YOU HAD OR HAVE ANY OF THE FOLLOWING? (Please circle Yes or No for each)

Yes / No	Heart Disease	Yes / No	AIDS/HIV	Yes / No	Psychiatric care
Yes / No	Surgeries	Yes / No	Osteoporosis	Yes / No	Family History of Heart Disease
Yes / No	Heart Attack	Yes / No	Hospitalization	Yes / No	Thyroid Disease
Yes / No	Artificial Joint(s)	Yes / No	Diabetes	Yes / No	Asthma
Yes / No	Ulcers	Yes / No	Hepatitis	Yes / No	Family History of Diabetes
Yes / No	Heart Defects	Yes / No	Tumors/Cancer	Yes / No	Sexually Transmitted Disease
Yes / No	Heart Murmur	Yes / No	Herpes	Yes / No	Chemotherapy
Yes / No	Radiation	Yes / No	Cold Sores	Yes / No	Rheumatic Fever
Yes / No	Skin Disease	Yes / No	Anemia	Yes / No	Arthritis/Rheumatism
Yes / No	Liver Disease	Yes / No	Lung Disease	Yes / No	Hardening of Arteries
Yes / No	Eye Disease	Yes / No	Seizures	Yes / No	High Blood Pressure
Yes / No	Stroke	Yes / No	Transplants	Yes / No	Emphysema/Lung Disease
Yes / No	Eating Disorder	Yes / No	Tuberculosis	Yes / No	Cosmetic Surgery

IV. ARE YOU ALLERGIC TO OR HAVE HAD A REACTION TO ANY OF THE FOLLOWING? (Please circle Yes or No for each)

Yes / No	Aspirin	Yes / No	Valium	Yes / No	Tetracycline
Yes / No	Darvon	Yes / No	Demerol	Yes / No	Vicodin
Yes / No	Codeine	Yes / No	Penicillin	Yes / No	Percodan
Yes / No	Latex	Yes / No	Food	Yes / No	Nitrous Oxide
Yes / No	Metals	Yes / No	Anesthetics	Yes / No	Erythromycin

Others: _____

V. ARE YOU TAKING OR HAVE TAKEN ANY OF THE FOLLOWING IN THE LAST THREE MONTHS? (Please circle Yes or No for each)

Yes / No	Recreation Drugs	Yes / No	Antibiotics	Yes / No	Tobacco in any form
Yes / No	OTC Medications	Yes / No	Alcohol	Yes / No	Supplements
Yes / No	Bisphosphonate	Yes / No	Aspirin	Yes / No	Weight Loss Medications

Please list all prescription medication:_____

VI. **WOMEN ONLY** (Please circle Yes or No for each)

Yes / No Are you or could you be pregnant? If yes, when are you due?_____
Yes / No Are you nursing?
Yes / No Are you taking birth control pills?

VII. **ALL** PATIENTS (Please circle Yes or No for each)

Yes / No Do you have or have had any other diseases or medical problems NOT listed on this form?
If YES, please explain: _____

_____

Yes / No Have you ever been pre-medicated for dental treatment?
If YES, why? _____
Yes / No Have you ever taken Fen-Phen?
If YES, when: _____

Yes / No **Is there any issue or condition that you would like to discuss with Dr. Flores in private?**

We believe that the practice of dentistry involves treating the whole person. If Dr. Flores determines that there be a potentially medically-compromised situation, a medical consultation may be needed prior to commencement of dental treatment.

I authorize Flores Family Dental to contact my physician.

Patient's Signature: _____ Date: _____

Physician's Name: _____ Phone: _____

I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform Dr. Flores & staff of any change in my health and/or medication. Further, I will not hold Dr. Flores or any member of his staff, responsible for any errors or omissions that I may have made in the completion of this form.

_____ _____
Signature of Patient (Parent or Guardian) Date

_____ _____
Dr. Michael L. Flores Date

Notice of Privacy Practices

This notice describes how health information about you may be used and disclosed, and how you can get access to this information.

Please review it carefully.

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 **February 16, 2026** and replaces all prior versions.

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.

SPECIALLY PROTECTED RECORDS (SUBSTANCE USE DISORDER TREATMENT RECORDS)

Certain health records related to substance use disorder diagnosis, treatment, or referral may be protected under additional federal law (42 CFR Part 2). When applicable, these records may require additional authorization for disclosure and may be subject to stricter confidentiality protections.

We will comply with all federal and state laws governing these records.

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 dentist, 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 information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. 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. By state law, your authorization is valid for 90 days.

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 you 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. In the 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 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 if we 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 health or 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 disclose 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 (such as voicemail messages, postcards, or letters).

Electronic Communications: We may communicate with you via email, text messaging, or patient portal messaging for appointment reminders, treatment information, billing, or care coordination. Electronic communications may carry some risk of unauthorized access. By providing your contact information, you acknowledge and accept this risk unless you request alternative communication methods in writing.

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 in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we may charge you $0.83 for each page up to thirty (30) and $0.63 for each page after thirty, a $19 administrative fee to locate and copy your health information, and postage if you want the copies mailed to you. Radiographs (x-rays) will be duplicated at a reasonable fee. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this 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 in a 12-month period, we may charge you a reasonable cost-based fee for responding to these additional 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 if we do, we will abide by our agreement (except in an emergency).

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 in writing. Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

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

Electronic Notice: If you receive this Notice on a Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Privacy Officer: Dr. Michael Flores/Ky Bryan

Telephone: (702) 242.3373
Fax: (702) 396.5318

Address: Flores Family Dental
6536 N. Decatur Blvd. Ste 120
Las Vegas, NV 89131

Dr. Michael Flores
Flores Family Dental

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES AND OFFICE POLICIES

You May Refuse to Sign This Acknowledgement

I, _____, have received a copy of this office's privacy practices & polices.

_____
Please Print Name

_____
Signature

_____
Date

The names below are individual(s)/organization(s) authorized to discuss my treatment plan options with Dr. Flores and his team.

Write "none" if you do NOT authorize anyone other than yourself or parent/guardian.

Effective *immediately* until provided written notice by patient/parent/guardian.

_____

_____

_____

_____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our privacy practices and office policies, as required by law, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify:

  _____