

Patient Information

Dr. Larry S. Frugoli D.M.D.

1010 Caughlin Crossing
Reno, Nevada 89519

Patient Name: _____ Preferred Name: _____ Date: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Adult ☐ Minor

Social Security # _____ Birth Date: _____

Phone Home # _____ Work # _____ Cell # _____

Home Address _____
Street *City* *Zip*

Mailing Address _____
Street *City* *Zip*

Referred By _____ E-mail _____

Person Responsible for Account

Name: _____

Relationship to Patient ☐ Self ☐ Spouse ☐ Parent ☐ Other _____

Patient s Employer: _____

Insurance Information

PRIMARY

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last *First* *MI*

Insured's Birth Date: _____ SS # _____ Group # _____

Insured's Address _____
Street *City* *Zip*

Insured's Employer Name: _____

Employer Address: _____
Street *City* *Zip*

Insurance Plan Name: _____

Address: _____
Street *City* *Zip*

SECONDARY

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last *First* *MI*

Insured's Birth Date: _____ SS # _____ Group # _____

Insured's Address _____
Street *City* *Zip*

Insured's Employer Name: _____

Employer Address: _____
Street *City* *Zip*

Insurance Plan Name: _____

Address: _____
Street *City* *Zip*

Emergency Contact Information

In case of emergency we can contact: _____

Phone Number: _____ Alternate Number: _____

Relationship to Patient: _____

Consent For Service

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist and/or dental staff.

I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the cost incurred in their care, and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patients account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1 and 1/2 percent per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial agreements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of 6 months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the doctor, I agree to pay therefore the reasonable value of said services to said doctor, or assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breech of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee to telephone me at home, work or mobile phone to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient _____

Signature of Patient, Parent or Guardian

_____ Date: _____ Relationship to Patient _____

Signature of guarantor of payment/responsible party

Payment is due in full at time of treatment, unless prior arrangements have been approved.

MEDICAL HISTORY

Patient Name _____ Nickname _____ Age _____

Name of Physician/and their specialty _____

Most recent physical examination _____ Purpose _____

What is your estimate of your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

DO YOU HAVE or HAVE YOU EVER HAD:	YES	NO
1. hospitalization for illness or injury_____	☐	☐
2. an allergic reaction to _____	☐	☐
☐ aspirin, ibuprofen, acetaminophen, codeine		
☐ penicillin		
☐ erythromycin		
☐ tetracycline		
☐ sulfa		
☐ local anesthetic		
☐ fluoride		
☐ metals (nickel, gold, silver, _____)		
☐ latex		
☐ other _____		
3. heart problems, or cardiac stent within the last six months __	☐	☐
4. history of infective endocarditis _____	☐	☐
5. artificial heart valve, repaired heart defect (PFO) _____	☐	☐
6. pacemaker or implantable defibrillator _____	☐	☐
7. orthopedic implant (joint replacement)_____	☐	☐
8. rheumatic or scarlet fever_____	☐	☐
9. high or low blood pressure_____	☐	☐
10. a stroke (taking blood thinners) _____	☐	☐
11. anemia or other blood disorder _____	☐	☐
12. prolonged bleeding due to a slight cut (INR > 3.5) _____	☐	☐
13. emphysema, shortness of breath, sarcoidosis _____	☐	☐
14. tuberculosis, measles, chicken pox_____	☐	☐
15. asthma _____	☐	☐
16. breathing or sleep problems (i.e. sleep apnea, snoring, sinus)	☐	☐
17. kidney disease _____	☐	☐
18. liver disease _____	☐	☐
19. jaundice _____	☐	☐
20. thyroid, parathyroid disease, or calcium deficiency _____	☐	☐
21. hormone deficiency _____	☐	☐
22. high cholesterol or taking statin drugs _____	☐	☐
23. diabetes (HbA1c =_____)_____	☐	☐
24. stomach or duodenal ulcer _____	☐	☐
25. digestive disorders (i.e. celiac disease, gastric reflux) _____	☐	☐
26. osteoporosis/osteopenia (i.e. taking bisphosphonates) __	☐	☐

	YES	NO
27. arthritis _____	☐	☐
28. autoimmune disease _____ (i.e. rheumatoid arthritis, lupus, scleroderma)	☐	☐
29. glaucoma _____	☐	☐
30. contact lenses _____	☐	☐
31. head or neck injuries _____	☐	☐
32. epilepsy, convulsions (seizures) _____	☐	☐
33. neurologic disorders (ADD/ADHD, prion disease) _____	☐	☐
34. viral infections and cold sores _____	☐	☐
35. any lumps or swelling in the mouth_____	☐	☐
36. hives, skin rash, hay fever_____	☐	☐
37. STI / STD / HPV _____	☐	☐
38. hepatitis (type ___) _____	☐	☐
39. HIV / AIDS _____	☐	☐
40. tumor, abnormal growth_____	☐	☐
41. radiation therapy_____	☐	☐
42. chemotherapy, immunosuppressive medication _____	☐	☐
43. emotional difficulties_____	☐	☐
44. psychiatric treatment_____	☐	☐
45. antidepressant medication _____	☐	☐
46. alcohol / recreational drug use _____	☐	☐
ARE YOU:		
47. presently being treated for any other illness _____	☐	☐
48. aware of a change in your health in the last 24 hours (i.e. fever, chills, new cough, or diarrhea) _____	☐	☐
49. taking medication for weight management _____	☐	☐
50. taking dietary supplements_____	☐	☐
51. often exhausted or fatigued _____	☐	☐
52. experiencing frequent headaches_____	☐	☐
53. a smoker, smoked previously or use smokeless tobacco _	☐	☐
54. considered a touchy / sensitive person _____	☐	☐
55. often unhappy or depressed_____	☐	☐
56. taking birth control pills _____	☐	☐
57. currently pregnant _____	☐	☐
58. prostate disorders _____	☐	☐

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment. (i.e. Botox, Collagen Injections)

_____

List all medications, supplements, and or vitamins taken within the last two years.

Drug	Purpose	Drug	Purpose

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

ASA _____ (1-6)

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DENTAL HISTORY

Name_____ Nickname_____ Age_____

Referred by_____ How would you rate the condition of your mouth? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Previous Dentist _____ How long have you been a patient?_____Months/Years

Date of most recent dental exam _____/_____/_____ Date of most recent x-rays _____/_____/_____

Date of most recent treatment (other than a cleaning) _____/_____/_____

I routinely see my dentist every: ☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

	YES	NO
PERSONAL HISTORY		
1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [___]	☐	☐
2. Have you had an unfavorable dental experience?	☐	☐
3. Have you ever had complications from past dental treatment?	☐	☐
4. Have you ever had trouble getting numb or had any reactions to local anesthetic?	☐	☐
5. Did you ever have braces, orthodontic treatment or had your bite adjusted?	☐	☐
6. Have you had any teeth removed or missing teeth that never developed?	☐	☐
GUM AND BONE		
7. Do your gums bleed or are they painful when brushing or flossing?	☐	☐
8. Have you ever been treated for gum disease or been told you have lost bone around your teeth?	☐	☐
9. Have you ever noticed an unpleasant taste or odor in your mouth?	☐	☐
10. Is there anyone with a history of periodontal disease in your family?	☐	☐
11. Have you ever experienced gum recession?	☐	☐
12. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple?	☐	☐
13. Have you experienced a burning or painful sensation in your mouth not related to your teeth?	☐	☐
TOOTH STRUCTURE		
14. Have you had any cavities within the past 3 years?	☐	☐
15. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food?	☐	☐
16. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth?	☐	☐
17. Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth?	☐	☐
18. Do you have grooves or notches on your teeth near the gum line?	☐	☐
19. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling?	☐	☐
20. Do you frequently get food caught between any teeth?	☐	☐
BITE AND JAW JOINT		
21. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping)	☐	☐
22. Do you feel like your lower jaw is being pushed back when you bite your teeth together?	☐	☐
23. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods?	☐	☐
24. Have your teeth changed in the last 5 years, become shorter, thinner or worn?	☐	☐
25. Are your teeth becoming more crooked, crowded, or overlapped?	☐	☐
26. Are your teeth developing spaces or becoming more loose?	☐	☐
27. Do you have more than one bite, squeeze, or shift your jaw to make your teeth fit together?	☐	☐
28. Do you place your tongue between your teeth or close your teeth against your tongue?	☐	☐
29. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits?	☐	☐
30. Do you clench your teeth in the daytime or make them sore?	☐	☐
31. Do you have any problems with sleep (i.e. restlessness), wake up with a headache or an awareness of your teeth?	☐	☐
32. Do you wear or have you ever worn a bite appliance?	☐	☐
SMILE CHARACTERISTICS		
33. Is there anything about the appearance of your teeth that you would like to change?	☐	☐
34. Have you ever whitened (bleached) your teeth?	☐	☐
35. Have you felt uncomfortable or self conscious about the appearance of your teeth?	☐	☐
36. Have you been disappointed with the appearance of previous dental work?	☐	☐

Patient's Signature _____ Date_____

Doctor's Signature _____ Date _____

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CAUGHLIN CROSSING COSMETIC & FAMILY DENTISTRY



Office Policy

Welcome to Caughlin Crossing Dentistry Our interest is to provide our patients with the finest possible dental care. As your provider, we advise treatment that is in the best interest of your medical and dental health. Be aware, often insurance companies select the dental procedures that they will and will not cover without any regard to you and your situation, dental needs and health. The following is an overview of our office financial policy

Insurance: Dental Insurance very rarely pays at 100% of all dental services. As a courtesy, we will bill your dental insurance for your visit with us, providing you give us your most current dental insurance for claim submission. Your estimated Co-Pays and estimated portion is due at time of
service and any un-paid after the claim settles is due within 14 days of receipt of statement.

Initials_____

Payment from your insurance company is expected with in 30 days. If your insurance company has not responded within a 60 days grace period from the date of service, the remaining balance in full is your responsibility. At the time of service, we will request from you initial down-payment, this is a
estimated portion of the charges which insurance may not cover, including all applicable deductibles and co-pays.

Initials_____

Estimates: Before treatment, we will perform a diagnosis and provide you with an estimate of the charges involved. As treatment progresses, it is a possibility the additional circumstances not be apparent at the initial exam, may be encountered. In this event, we will discuss options with you and proceed as necessary upon your agreement.

Initials_____

Payment: Payment in full is required at the time of service. For your convenience, we accept debit and credit cards including Visa, MasterCard, Discover, American Express and checks, we also accept Care credit.

Initials_____

Aged Account: The total balance on your account, after claim and settlement, is due upon receipt of statement. Failure to keep this account current may result in Caughlin Crossing Dentistry being unable to provide additional dental services. In the event of a default, I agree that any information collected can be used to collect on my account, and I agree to pay all costs incurred in the attempt to collect on this account, including late fees of $30.00, fiance charge, service and/or collection agency fees, attorney's fees and court costs.

Initials_____

Appointments: If you are unable to keep a scheduled appointment, we ask that you provide us with a 48 hour notice as a courtesy. Notice of less the 48 hours may result in a minimum charge of $75.00. We do not over-book our schedule. This means your appointment time is reserved especially for you. If you do not come, not only is your dental care delayed, but other patients are not able to be treated during that time. If you absolutely must reschedule, please give at least 24 hour notice to avoid an appointment fee. Larger appointments that require 2 or more hours may require more advanced cancellation notice with a possible deposit toward your treatment.

CAUGHLIN CROSSING COSMETIC & FAMILY DENTISTRY



Confirmation: 24 hours prior to your scheduled appointment a confrontation by phone,text, or rmail is required or will result in a non refundable fee of a $100.00

Initials _____

I agree to be responsivle for all charges for dental services and materials not paid by my dental benefit plan. I conseent to your use and disclosure of my protected health information to carry out payment activities in connection with my dental claims. I hereby authorize and direct payment of dental benefits otherwise payable to me,directly to Caughlin Crossing Dentistry.

I have read, understand, and agree to the above.

_____

Signature of person responsible for account

_____

Printed name of person responsible for account

_____

Date

NOTICE OF PRIVACY PRACTICES

Effective Date: [02/16/2026]

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

OUR RESPONSIBILITIES

We are required by law to:

- Maintain the privacy of your protected health information (PHI)
- Provide you with this Notice of our legal duties and privacy practices
- Follow the terms of the Notice currently in effect

HOW WE MAY USE AND DISCLOSE YOUR INFORMATION

For Treatment

We may use or share your health information to provide, coordinate, or manage your dental care.

Example: Sharing X-rays with a specialist or another dentist involved in your care.

For Payment

We may use or share your information to bill and receive payment for services.

Example: Submitting claims to insurance or contacting you about balances.

For Health Care Operations

We may use or share your information to run our practice, improve quality, and train staff.

Example: Internal audits, training, quality improvement.

OTHER PERMITTED USES AND DISCLOSURES

We may also use or share your information:

- As required by law
- For public health activities
- To prevent or reduce a serious threat to health or safety
- For workers' compensation or law enforcement purposes, as allowed by law

SPECIAL PROTECTIONS FOR CERTAIN INFORMATION (Part 2 / SUD Records)

If our practice maintains records related to **substance use disorder (SUD) treatment,** those records receive **additional protections under federal law**.

- If such information is received under a **general authorization** that permits use and disclosure for treatment, payment, or health care operations, as described above, we will use the information for some or all of those purposes.
- If such information is received under a **specific authorization**, we will use and disclose only as allowed under that specific authorization.
- Such information **will not be shared without your written authorization**, except as permitted or required by law.
- Once shared with your written consent, the information **may be redisclosed by HIPAA entities,** in accordance with HIPAA regulations.
- Such information, if de-identified, may be disclosed to public health authorities **without your written consent.**

YOUR RIGHTS

You have the right to:

✓ Get a Copy of Your Records

You may request access to our copies of your dental records. We may charge a reasonable fee.

✓ Request Corrections

If you believe information is incorrect or incomplete, you may request an amendment.

✓ Request Confidential Communications

You can ask us to contact you in a specific way (e.g., phone instead of mail).

✓ Request Restrictions

You may request limits on how your information is used or shared. We are not required to agree in all cases.

✓ Get a List of Disclosures

You can request a list of certain disclosures we have made.

✓ Receive a Paper Copy of This Notice

You may request a paper copy at any time.

OUR USES AND DISCLOSURES THAT REQUIRE YOUR AUTHORIZATION

We will **not** use or disclose your information for purposes such as marketing or sharing with third parties **without your written authorization**, unless permitted by law.

You may revoke an authorization at any time in writing.

CHANGES TO THIS NOTICE

We reserve the right to change this Notice and make the revised Notice effective for information we already have. The updated Notice will be posted in our office and on our website (if applicable).

COMPLAINTS

If you believe your privacy rights have been violated, you may:

- File a complaint with our office
- File a complaint with the U.S. Department of Health and Human Services

You will **not** be retaliated against for filing a complaint.

CONTACT INFORMATION

Privacy Officer: Human Resources

Phone: (480) 626-4118

Email: HR [redacted]

Office Address: 1010 Caughlin Crossing
Reno, NV 89519

Acknowledgment of Receipt (Recommended)

I acknowledge that I have received a copy of the Notice of Privacy Practices.

Patient Name: _____

Signature: _____

Date: _____

Medical Information Release Form

(HIPAA Release Form)

Name: _____ **Date of Birth:** ____/____/____

Release of Information

[ ] I authorize the release of information including the diagnosis, records, examination rendered to me and claims information. This information may be released to

[ ] Spouse_____

[ ] Child(ren)_____

[ ] Other_____

[ ] Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

Messages

Please call [ ] my home [ ] my work [ ] my cell Number _____

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ] _____

The best time to reach me is (*day*)_____ between (*time*)_____

Signed: _____ Date: ____/____/____

Witness _____ Date: ____/____/____