

Welcome!

Daniel J Oehler, DMD
Flamingo Family Dental
flamingofamilydental.com

Today's Date _____

PATIENT INFORMATION (Please Print)

SSN# _____

Name _____ Birthdate _____ Home Phone () _____

Cell Phone() _____ Email _____

I Would Like to Receive Email Reminders: YES / NO

Text Reminders?: YES / NO

Address _____ City _____ State _____ Zip _____

Check Appropriate Box: Male Female Status: Minor Single Married Divorced Widowed Separated

Name of School Attending _____ City _____ Full Time Part Time

Employer _____ Work Phone () _____ City _____ State _____

Spouse or Parent's Name _____ Employer _____ Work Phone () _____

Emergency Contact (not living at your home) _____ Phone () _____

Who can we thank for referring you to our office today? _____

For your convenience, we offer the following methods of payment. **Please check** the option you prefer. Payment is required at the time of service.

CASH PERSONAL CHECK VISA MASTERCARD AMERICAN EXPRESS CARE CREDIT

INSURANCE INFORMATION

(Please present your Insurance Card and Driver's License)

Name of Insured _____ Relationship to Patient _____

Insured's Address _____ City _____ State _____ Zip _____

Birthdate _____ SSN# _____ ID# _____ Group # _____

Name of Employer _____ Insurance Company _____

Secondary Insurance

Name of Insured _____ Relationship to Patient _____

Insured's Address _____ City _____ State _____ Zip _____

Birthdate _____ SSN# _____ ID# _____ Group # _____

Name of Employer _____ Insurance Company _____

PATIENT MEDICAL HISTORY

Physician _____ City _____ Date of Last Exam _____

- Are you under a physician's care now? Yes No If Yes, explain _____
- Have you ever been hospitalized or had a major operation? Yes No If Yes, explain _____
- Have you ever had a serious head or neck injury? Yes No If Yes, explain _____
- Are you taking any medications, pills, or drugs? Yes No If Yes, explain or attach list _____

WOMEN: Are you Pregnant/Trying to get pregnant? Nursing? Taking oral contraceptives?

Allergies

Are you allergic to any of the following?

- Acrylic Aspirin Codeine Erythromycin Iodine Metal Latex Local Anesthetics Penicillin Sedatives Sulfa Drugs
 Other If yes, please explain: _____

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

- | | | | |
|--|---|---|--|
| <input type="radio"/> Allergies | <input type="radio"/> Coumadin | <input type="radio"/> High Blood Pressure | <input type="radio"/> Radiation Treatment |
| <input type="radio"/> Alzheimers | <input type="radio"/> Diabetes | <input type="radio"/> HIV - AIDS | <input type="radio"/> Respiratory Problems |
| <input type="radio"/> Anemia | <input type="radio"/> Dizziness | <input type="radio"/> Hives or Rash | <input type="radio"/> Rheumatic/Scarlet Fever |
| <input type="radio"/> Anxiety | <input type="radio"/> Emphysema | <input type="radio"/> Jaundice | <input type="radio"/> Rheumatism |
| <input type="radio"/> Arthritis | <input type="radio"/> Epilepsy or Seizures | <input type="radio"/> Kidney Disease | <input type="radio"/> Shingles |
| <input type="radio"/> Artificial Heart Valve | <input type="radio"/> Excessive Bleeding | <input type="radio"/> Liver Disease | <input type="radio"/> Sinus Problems |
| <input type="radio"/> Artificial Joints | <input type="radio"/> Fainting Spells/Dizziness | <input type="radio"/> Low Blood Pressure | <input type="radio"/> Stomach Problems |
| <input type="radio"/> Asthma | <input type="radio"/> Glaucoma | <input type="radio"/> Mitral Valve Prolapse | <input type="radio"/> Stroke |
| <input type="radio"/> Back Problems | <input type="radio"/> Hay Fever | <input type="radio"/> Multiple Sclerosis | <input type="radio"/> Thyroid Condition/Goiter |
| <input type="radio"/> Barbituates | <input type="radio"/> Head Injuries | <input type="radio"/> No EPI | <input type="radio"/> TMJ |
| <input type="radio"/> Blood Transfusion | <input type="radio"/> Heart Disease | <input type="radio"/> Pace Maker | <input type="radio"/> Tuberculosis |
| <input type="radio"/> Bruise Easily | <input type="radio"/> Heart Murmur | <input type="radio"/> Parkinsons | <input type="radio"/> Tumors or Growths |
| <input type="radio"/> Cancer | <input type="radio"/> Hepatitis | <input type="radio"/> Psychiatric Care | <input type="radio"/> Ulcers |

Have you ever had any serious illness not listed above? Yes No If yes, please explain _____

Smile Survey

If you could change your smile, would you:

- | | | |
|--|--|---|
| <input type="radio"/> Make your teeth whiter | <input type="radio"/> Make your teeth straighter | <input type="radio"/> Close spaces between your teeth |
| <input type="radio"/> Repair chipped teeth | <input type="radio"/> Replace missing teeth | <input type="radio"/> Replace old crowns that don't match |

Any other concerns – including teeth grinding, snore guards or sleep apnea? _____

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 dental office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. I authorize the dentist to release any information including the diagnosis and the records 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 practioners. I authorize and request my insurance company to pay directly to the dentist or dental or dental group, benefits otherwise payable to me. If I have dental insurance, I understand I am responsible for any fees not covered by my dental insurance plan.

Signature of patient (or parent if minor) Printed Name Date

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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name _____

Address: _____

Telephone : _____ E-mail: _____

Patient #: _____ Social Security#: _____

SECTION B: TO THE PATIENT - PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your-protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: PAMELA FRYMAN OR MICHELE OEHLER

Telephone: 702-731-2757 Fax: 702-732-4822

E-mail: Flamingo2675@yahoo.com

Address: 2675 E. FLAMINGO RD., STE 3, LAS VEGAS, NV 89121

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____ have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature

Date

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

ACKNOWLEDGEMENT OF RECEIPT OF 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

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, 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)

