

# Welcome

Today's Date: \_\_\_\_\_

PLEASE PRINT

I Would Like to Receive Email Correspondence

Email \_\_\_\_\_

SSN# \_\_\_\_\_

## Patient Information (CONFIDENTIAL)

Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Home Phone (\_\_\_\_) \_\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Address 2 \_\_\_\_\_ 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 (\_\_\_\_) \_\_\_\_\_

Person to Contact in Case of Emergency (not living at your home) \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

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

## Responsible Party

Name of Person Responsible for this Account \_\_\_\_\_ DRIVER'S LICENSE # \_\_\_\_\_

Address \_\_\_\_\_ Home Phone \_\_\_\_\_

Address 2 \_\_\_\_\_ Email \_\_\_\_\_

Birthdate \_\_\_\_\_ SSN# \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Employer \_\_\_\_\_ City \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_

Is this Person Currently a Patient in our Office?  Yes  No

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

## 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

Please list: \_\_\_\_\_

- ▶ Do you, or have you taken **Phen-Fen** or **Redux**?  Yes  No
- ▶ Are you on a special diet?  Yes  No
- ▶ Do you use Tobacco?  Yes  No
- ▶ Do you use controlled substances?  Yes  No
- ▶ Do you take medication for **Osteoporosis**?  Yes  No If Yes Please List \_\_\_\_\_

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

## Allergies

Are you allergic to any of the following?

- Aspirin  Penicillin  Codeine  Acrylic  Metal  Latex  Local Anesthetics  Sulfa  
 Other (if yes, please explain:) \_\_\_\_\_

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

<input type="radio"/> AIDS/HIV positive	<input type="radio"/> Chest Pains	<input type="radio"/> Frequent Headaches	<input type="radio"/> Irregular Heartbeat	<input type="radio"/> Scarlet Fever
<input type="radio"/> Alzheimer's Disease	<input type="radio"/> Cold sores/Fever Blisters	<input type="radio"/> Genital Herpes	<input type="radio"/> Kidney disease	<input type="radio"/> Shingles
<input type="radio"/> Anaphylaxis	<input type="radio"/> Congenital Heart Disorder	<input type="radio"/> Glaucoma	<input type="radio"/> Leukemia	<input type="radio"/> Sickle Cell Disease
<input type="radio"/> Anemia	<input type="radio"/> Convulsions	<input type="radio"/> Hay Fever	<input type="radio"/> Liver Disease	<input type="radio"/> Sinus Trouble
<input type="radio"/> Angina	<input type="radio"/> Cortisone Medicine	<input type="radio"/> Heart Attack/Failure	<input type="radio"/> Low Blood Pressure	<input type="radio"/> Spina Bifida
<input type="radio"/> Arthritis/Gout	<input type="radio"/> Diabetes	<input type="radio"/> Heart Murmur	<input type="radio"/> Lung Disease	<input type="radio"/> Stomach/Intestinal Disease
<input type="radio"/> Artificial Heart Valve	<input type="radio"/> Drug Addiction	<input type="radio"/> Heart Pace Maker	<input type="radio"/> Mitral Valve Prolapse	<input type="radio"/> Stroke
<input type="radio"/> Artificial Joint	<input type="radio"/> Easily Winded	<input type="radio"/> Heart Trouble/Disease	<input type="radio"/> Pain in Jaw Joints	<input type="radio"/> Swelling of Limbs
<input type="radio"/> Asthma	<input type="radio"/> Emphysema	<input type="radio"/> Hemophilia	<input type="radio"/> Parathyroid Disease	<input type="radio"/> Thyroid Disease
<input type="radio"/> Blood Disease	<input type="radio"/> Epilepsy or Seizures	<input type="radio"/> Hepatitis A	<input type="radio"/> Psychiatric Care	<input type="radio"/> Tonsillitis
<input type="radio"/> Blood Thinner	<input type="radio"/> Excessive Bleeding	<input type="radio"/> Hepatitis B or C	<input type="radio"/> Radiation Treatments	<input type="radio"/> Tuberculosis
<input type="radio"/> Breathing Problem	<input type="radio"/> Excessive Thirst	<input type="radio"/> Herpes	<input type="radio"/> Recent Weight Loss	<input type="radio"/> Tumors or Growths
<input type="radio"/> Bruise Easily	<input type="radio"/> Fainting Spells/Dizziness	<input type="radio"/> High Blood Pressure	<input type="radio"/> Renal Dialysis	<input type="radio"/> Ulcers
<input type="radio"/> Cancer	<input type="radio"/> Frequent Cough	<input type="radio"/> Hives or Rash	<input type="radio"/> Rheumatic Fever	<input type="radio"/> Venereal Disease
<input type="radio"/> Chemotherapy	<input type="radio"/> Frequent Diarrhea	<input type="radio"/> Hypoglycemia	<input type="radio"/> Rheumatism	<input type="radio"/> Yellow Jaundice

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

## Dental History

Name of Previous Dentist \_\_\_\_\_ Location \_\_\_\_\_

Date of Last Visit \_\_\_\_\_ Date of Last Dental X-rays \_\_\_\_\_

## 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.

Signature of patient (or parent if minor) \_\_\_\_\_

Printed Name \_\_\_\_\_

Date \_\_\_\_\_

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# CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

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## SECTION A: PATIENT GIVING CONSENT

Name \_\_\_\_\_

Address: \_\_\_\_\_

Telephone : \_\_\_\_\_ E-mail: \_\_\_\_\_

Patient #: \_\_\_\_\_ Social Security#: \_\_\_\_\_

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## 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:** \_\_\_\_\_  
**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: \_\_\_\_\_

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**ACKNOWLEDGEMENT OF RECEIPT OF  
NOTICE OF PRIVACY PRACTICES**

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\* 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

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**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)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_