DANIEL J. OEHLER, DMD
FAMILY DENTISTRY

DanielOehlerDMD.com

PATIENT INFORMATION (Please Print)

Today's Date _____ SSN# _____

Name _____ Birthdate _____ Home Phone ( )_____

Cell Phone( )_____ Email_____

Please circle preferred method of contact: **Home Phone** **Email** **Cell Phone - Name of Carrier (i.e. Verizon)**_____

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? O Yes O No If Yes, explain _____
- Have you ever been hospitalized or had a major operation? O Yes O No If Yes, explain _____
- Have you ever had a serious head or neck injury? O Yes O No If Yes, explain _____
- Please list any medications, pills, or drugs you are taking: _____

_____

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

Allergies

Are you allergic to any of the following?

O Acrylic O Aspirin O Codeine O Erythromycin O Iodine O Metal O Latex O Local Anesthetics O Penicillin O Sedatives O Sulfa Drugs

O Other If yes, please explain: _____

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

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

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

_____

Smile Survey

If you could change your smile, would you:

O Make your teeth whiter O Make your teeth straighter O Close spaces between your teeth

O Repair chipped teeth O Replace missing teeth O 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*

_____

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

_____

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

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: dr.oehler@yahoo.com

Address: 731 Mall Ring Circle #203, Henderson, NV 89014

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: _____