

OASIS DENTAL
2110 East Flamingo Road
Suite 315
Las Vegas, NV 89119
702 369-0021

WELCOME TO OUR OFFICE

We would like to welcome you as a patient. Your initial visit to our office will consist of obtaining a thorough medical and dental history, a full mouth examination, and any necessary X-rays. A description of the treatment needed for your best dental care will be discussed as well as a prognosis, an estimated fee, and time required for proposed treatment. You are encouraged to ask any questions you have regarding your treatment. Our staff is here to serve you as a team to ensure you receive excellent dental care.

Fees and Payments

We offer four payments options:

1. Cash
2. Check
3. Credit card: Visa, MasterCard, Discover, or American Express
4. Care Credit (like a dental credit card with low or no interest. Ask our staff to apply for Care Credit)

MISSED APPOINTMENTS

48 HOURS NOTICE IS REQUIRED TO CANCEL OR RESCHEDULE AN APPOINTMENT.

By scheduling your dental treatment and not keeping your appointment, you are preventing other patients from being seen by the dentist. Although Oasis Dental will make every effort to confirm appointments the day before, it is the patient's responsibility to remember your appointments. If you fail to provide Oasis Dental with 48 hours notice, a **\$50.00 charge per hour scheduled** will be charged. By signing this document, you agree to pay this charge and understand that no further services will be provided until your balance is paid in full.

INSURANCE

Please remember that most insurance companies DO NOT cover all dental costs. Most companies pay fixed portions of the full charge. It is your responsibility to pay any deductible, co-insurance, or other balance not paid by your insurance company. If your insurance company has not paid your account in full 45 days of billing, the balance is your responsibility. Please be aware that your insurance company may not cover all services offered by this office.

All co-pays and deductible are due at the time of services.

GETTING TO KNOW OUR NEW PATIENT

Patient Name	Social Security Number	Home Phone
Home Address	City, State, Zip	Birthdate
Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Single	Male Female <input type="checkbox"/> <input type="checkbox"/>	Driver's License and State
Primary Insurance Company _____ Group _____		Subscriber _____
Secondary Insurance Company _____ Group _____		Subscriber _____

Responsible Party		
Name	Social Security Number	Home Phone
Home Address	City, State, Zip	Birthdate
Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Single	Relationship to Patient	Driver's License and State
Responsible Person's Employer	Occupation	Work Phone
Business Address	City State Zip	
Spouse's Name	Social Security Number	Birthdate
Spouse's Employer	Spouse's Occupation	Spouse's Work Number
Spouse's Business Address	City State Zip	

HOW DID YOU HEAR ABOUT OUR OFFICE?

Employee Payroll Insert Flyer Insurance Plan Newspaper Ad
 Yellow Pages Building Sign Direct Mailing Other _____
 If you were referred, whom may we thank for referring you? _____

CONSENT

*I will answer all health questions to the best of my knowledge. _____ (Initial)

After explanation by the doctor, I hereby authorize the performance of dental services upon the above named patients and whatever procedures that the judgment of the doctor may dictate in order to carry out these procedures. I also authorize and request the administration of any anesthetics and x-ray as may be deemed necessary and advisable by the doctor.

Signature _____ **Date** _____ **Relationship to Patient** _____

I agree to pay for all services rendered. In the event that payment is not made within (30) days of receipt of statement, a service charge at the legal rate will be added to the past due balance. If a collection agency's services are required, I further agree to pay for all legal fees and costs incurred in connection therewith. Service charges not paid when due shall be added to and become part of the principal and bear like interest until paid in full. I also understand that in order to collect my debt, my credit history may be checked through the use of my Social Security number or any other information I have provided. I understand that any and all fees incurred for dental treatment are my total responsibility, regardless of any insurance benefit I may have. In the event that my insurance does not provide payment or provides a reduced payment benefit will be financially responsible to pay up to the agreed upon fee schedule.

Payment Preference Cash / Check on day of treatment Credit Card Debit Card

Signature _____ Date _____

There will be a charge for any missed or rescheduled appointments without 48 hours notice before the appointment time.

PATIENT'S DENTAL HEALTH

Why have you come to see us today? (i.e. pain, checkup, etc.) _____

Previous Dentist? _____ Last Visit? _____ Date of Last Cleaning? _____

Reason for changing dentists? _____

Have you had any problems with past dental treatment? _____

Are you nervous about seeing a dentist? Yes No If yes, please tell us why _____

How often do you brush? _____ Do you floss? Yes No How often? _____

(Please check Y for Yes or N for No)

<p><input type="checkbox"/> <input type="checkbox"/> I clench or grind my teeth during the day or while sleeping.</p> <p><input type="checkbox"/> <input type="checkbox"/> My gums bleed while brushing or flossing</p> <p><input type="checkbox"/> <input type="checkbox"/> My gums feel tender or swollen</p> <p><input type="checkbox"/> <input type="checkbox"/> I have problems eating</p> <p><input type="checkbox"/> <input type="checkbox"/> I avoid brushing part of my mouth due to pain</p> <p>What are your dental priorities? (e.g. appearance, dental health, etc.) _____</p>	<p style="text-align: center;">Y N</p> <p><input type="checkbox"/> <input type="checkbox"/> I like my smile</p> <p><input type="checkbox"/> <input type="checkbox"/> I prefer tooth colored fillings</p> <p><input type="checkbox"/> <input type="checkbox"/> I want my teeth straighter</p> <p><input type="checkbox"/> <input type="checkbox"/> I want my teeth whiter in color</p> <p><input type="checkbox"/> <input type="checkbox"/> I have had orthodontic treatment</p> <p><input type="checkbox"/> <input type="checkbox"/> I have had facial or jaw injury</p>
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PATIENT'S MEDICAL HISTORY

I consider my health to be: Excellent Good Fair Poor

Do you have or have you had any of the following? *(Please check Y for Yes or N for No)*

<p>Y N</p> <p><input type="checkbox"/> <input type="checkbox"/> Heart Disease</p> <p><input type="checkbox"/> <input type="checkbox"/> Heart Murmur / Mitral Valve Prolapse</p> <p><input type="checkbox"/> <input type="checkbox"/> Stroke</p> <p><input type="checkbox"/> <input type="checkbox"/> Congenital Heart Lesions</p> <p><input type="checkbox"/> <input type="checkbox"/> Rheumatic Fever</p> <p><input type="checkbox"/> <input type="checkbox"/> Abnormal Blood Pressure</p> <p><input type="checkbox"/> <input type="checkbox"/> Anemia</p> <p><input type="checkbox"/> <input type="checkbox"/> Prolonged Bleeding Disease</p> <p><input type="checkbox"/> <input type="checkbox"/> Tuberculosis or Lung Disease</p> <p><input type="checkbox"/> <input type="checkbox"/> Asthma</p> <p><input type="checkbox"/> <input type="checkbox"/> Hay Fever</p> <p><input type="checkbox"/> <input type="checkbox"/> Sinus Trouble</p> <p><input type="checkbox"/> <input type="checkbox"/> Epilepsy / Seizures</p> <p><input type="checkbox"/> <input type="checkbox"/> Ulcers</p> <p><input type="checkbox"/> <input type="checkbox"/> Implants / Artificial Joints: Hip - Knee - Teeth _____ Other _____</p> <p><input type="checkbox"/> <input type="checkbox"/> I smoke or use chewing tobacco. If yes, how much per day? _____ How many years? _____</p> <p><input type="checkbox"/> <input type="checkbox"/> I usually take an antibiotic prior to dental treatment.</p> <p><input type="checkbox"/> <input type="checkbox"/> I have had major surgery. Year _____ Type of operation _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Do you have any other medical problem or medical history NOT listed on this form?</p>	<p>Y N</p> <p><input type="checkbox"/> <input type="checkbox"/> Liver Disease</p> <p><input type="checkbox"/> <input type="checkbox"/> Jaundice</p> <p><input type="checkbox"/> <input type="checkbox"/> Hepatitis Type ____</p> <p><input type="checkbox"/> <input type="checkbox"/> Diabetes</p> <p><input type="checkbox"/> <input type="checkbox"/> Excessive Urination and/or Excess Thirst</p> <p><input type="checkbox"/> <input type="checkbox"/> Infectious Mononucleosis ("Mono")</p> <p><input type="checkbox"/> <input type="checkbox"/> Herpes</p> <p><input type="checkbox"/> <input type="checkbox"/> Arthritis</p> <p><input type="checkbox"/> <input type="checkbox"/> Venereal Disease</p> <p><input type="checkbox"/> <input type="checkbox"/> Kidney Disease</p> <p><input type="checkbox"/> <input type="checkbox"/> Tumor or Malignancy</p> <p><input type="checkbox"/> <input type="checkbox"/> Cancer/Chemotherapy</p> <p><input type="checkbox"/> <input type="checkbox"/> Radiation/Therapy</p> <p><input type="checkbox"/> <input type="checkbox"/> History of Drug Addiction</p>	<p>Y N</p> <p><input type="checkbox"/> <input type="checkbox"/> A.I.D.S or HIV Positive</p> <p><input type="checkbox"/> <input type="checkbox"/> Immune Suppressed Disorder</p> <p><input type="checkbox"/> <input type="checkbox"/> Hearing Loss</p> <p><input type="checkbox"/> <input type="checkbox"/> Fainting Spells</p> <p><input type="checkbox"/> <input type="checkbox"/> Glaucoma</p> <p><input type="checkbox"/> <input type="checkbox"/> Emotional /Nervous Disorders</p> <p style="text-align: center;">WOMEN</p> <p><input type="checkbox"/> <input type="checkbox"/> Are you taking birth control medications?</p> <p><input type="checkbox"/> <input type="checkbox"/> Are you pregnant or nursing?</p> <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> <p>Doctor Notes Only:</p> </div>
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<p>Are you allergic to any of the following?</p> <p>Y N</p> <p><input type="checkbox"/> <input type="checkbox"/> Aspirin/ Ibuprofen</p> <p><input type="checkbox"/> <input type="checkbox"/> Sulfa Drugs / Sulfites / Sulfides</p> <p><input type="checkbox"/> <input type="checkbox"/> Penicillin</p> <p><input type="checkbox"/> <input type="checkbox"/> Codeine</p> <p><input type="checkbox"/> <input type="checkbox"/> Latex, Metals, Plastics</p> <p><input type="checkbox"/> <input type="checkbox"/> Local Anesthetics (Novocaine)</p> <p><input type="checkbox"/> <input type="checkbox"/> Other Medications Which ones? _____</p>	<p style="text-align: center;">Please list all medications you are currently taking:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>Physician's Name _____ Phone _____</p> <p>Address _____ Fax _____</p>
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In the event of an emergency, please contact:

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

<p>Medical Health Reviewed by:</p> <p>X _____</p> <p style="text-align: center;">Doctor's Signature _____ Date _____</p>	<table style="width: 100%; border: none;"> <tr> <td style="width: 50%; text-align: center;">X _____</td> <td style="width: 50%; text-align: center;">_____</td> </tr> <tr> <td style="text-align: center;">Patient's Signature</td> <td style="text-align: center;">Date</td> </tr> <tr> <td style="text-align: center;">X _____</td> <td style="text-align: center;">_____</td> </tr> <tr> <td style="text-align: center;">Parent/Guardian Signature</td> <td style="text-align: center;">Date</td> </tr> </table>	X _____	_____	Patient's Signature	Date	X _____	_____	Parent/Guardian Signature	Date
X _____	_____								
Patient's Signature	Date								
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