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*