ERIC N. DAHLE, D.M.D. **General Dentistry** _______

478 SW 12th Street, Ontario, OR 97914

(541) 881-1794

Please fill out completely ***Date:*** ________________

Please Print Clearly

Patient's Full Name_______________________________ Male / Female Date of Birth_____________________

Residence Address ________________________________City________________State_________Zip__________

Mailing Address __________________________________City ________________State _________Zip __________

Home Phone # (____)_______________ Cell # (____)__________ Emergency# (____)__________________________

Email Address ____________________________________ Social Security #___________________________

***If Minor*, Parent's Full Name** ______________________________

☐ Patient ☐Parent Employed By ______________________Position _____________Phone#(____)______________

Business Address _________________________________City ________________State _________Zip __________

Spouse Full Name _________________________________Employed By ______________________________

Business Address _________________________________Position ____________________Phone #(____)_________

Person Responsible For Payment (Guarantor) ___________________________ Date of Birth ___________________

Address ____Phone#(____)______________________________

Guarantor's Social Security # _________________________ Driver's License# ____________State________________

****We need a copy of your driver's license, dental insurance card, and medical insurance cards.***

Dental Insurance? _____ If yes, Please complete the Dental Assignment Of Benefits Authorization form

Medical Insurance? _____ If yes, Please complete the Medical Assignment Of Benefits Authorization form

Name of Physician _______________________________City ____________________State ______________

Previous Dentist _________________________________City ____________________State ______________

Who may we thank for referring you? ____

Do you have or have you had any of the following: (Mark with an X for yes)

___Heart Attack
___Heart Surgery
___Diabetes
___High Blood Pressure
___Liver Disease
___Stroke
___Cancer or tumors
___Radiation treatment
___Pacemaker
___Angina/chest pains
___Ulcers
___Asthma
___Arthritis
___Prosthetic Appliance
___AIDS/ HIV

___Artificial Joints
___Anemia
___Kidney Disease
___Jaundice
___Venereal Disease
___Thyroid Problem
___Rheumatic Heart Disease
___Cardiac Valve Prosthesis
___Bleeding Disorder
___Tuberculosis
___Shortness of Breath
___Epilepsy
___Fainting Spells
___Hepatitis
___Infective Endocarditis

___Autism
___ADHD\ ADD
___Mental Disease
___Acid Reflux
___Dry Mouth
___Clicking Jaw Joint
___Jaw Joint Pain
___Chronic Headaches
___Migraines
___Bite Guard
___Grinding Teeth
___Clenching/ Gritting
___Severe Snoring
___Sleep Apnea
___C-PAP

Dry Mouth

►Are you interested in treatment for your dry mouth? ☐No ☐Yes

Headaches/ Migraines/ Head pain

►Do you suffer from chronic/ recurrent head/ neck/ jaw pain? ☐No ☐Yes

►What treatments, if any, have been effective at giving relief?

____

Sleep Apnea

►If you have a C-PAP machine, do you use it every night? ☐No ☐Yes

►Are you satisfied with the results? ☐No ☐Yes

(continued on back)

Health and Dental History

1. Do you have any allergies to medications, foods, or drugs? ☐No ☐Yes Please List
2. Have you had any major surgeries? ☐No ☐Yes Please List
   For?____
3. Are you currently being treated by a physician? ☐No ☐Yes
   For?____
4. Are you presently taking any medications or drugs? ☐No ☐Yes Please List
5. Women: Are you pregnant? ☐No ☐Yes Due:____________________
6. Do you use any tobacco products? ☐No ☐Yes
   If so, are you interested in quitting? ☐No ☐Yes
7. Have you ever been told by a physician that you need to take antibiotics prior to dental treatment (other than for a tooth infection)? ☐No ☐Yes
   If yes, For?__________________________________
8. What is your chief dental complaint?
   ____
9. Date of last set of full mouth x-rays or panoramic x-ray____________
   Date of last dental cleaning? ________________________
10. Have you ever experienced any unfavorable reaction to dental treatment?
    ☐No ☐Yes, please explain ________________________
11. Are you pleased with the appearance of your teeth? (i.e. gaps, crowding, yellowing, etc..) ☐No ☐Yes
12. Are you interested in being sedated to receive your dental treatment?
    ☐No ☐Yes

Allergy/ Reaction

____

____

Medication Name/ Purpose

____

____

____

____

____

____

FOR DOCTOR'S USE ONLY

Office Policies and Consent to Treatment

Please read and initial each policy

______ I hereby authorize the doctor to do examinations and to take radiographs, study models, photographs or employ any other diagnostic aids he deems appropriate to make a thorough diagnosis of my dental needs. I also authorize the doctor to perform any and all forms of treatment and therapy that may be indicated and to use and prescribe medications as necessary.

______ I understand that I am personally responsible for payment of all fees for dental services provided in this office for me or my dependents, regardless of insurance coverage. Payment is expected at the time of service, unless prior written arrangements have been made. Breach of this responsibility carries the penalty of compensating the practice for any related attorney's and collection fees.

______ In order to provide the best possible service to all our patients, please call as soon as you know you will need to reschedule your appointment as we require a minimum of **24 hours notice.** Please make any necessary arrangements sufficiently in advance. Repeated missed appointments or cancellations without a 24 hour notice may result in applicable fees and eventual closure of the family's files.

____________________________________ ________________

Signature Date