Welcome

Section I: **Patient Information** **Date: _______________**

Name: ____ Preferred Name: _____________________________

Physical Address: ____City: ______________________ State: _________Zip ________

Mailing Address: ____City _______________________ State: ___________Zip ________

Date of Birth: __________________ Age _______ Social Security Number: ______________________________

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Phone (_____) ___________________ Work Phone (_____) ___________________ Cell Phone (_____) ___________________

The **BEST** method for contacting me is: ☐ Home phone ☐ Cell phone ☐ Work phone

Employer/School ____ City/State ___________________________

Spouse or Parent's Name: _________________________________ Employer ____________________Work Phone _______________

Person to contact in case of emergency ______________________ Relationship ___________________ Phone___________________

Section II **Responsible Party** *(If different than Patient)*

Name: _____________________________________ Relationship to Patient: ____________________ Phone: (_____) ____________

Date of Birth: __________Address: ___________________________________City: ______________ State: _____ Zip ___________

Employer ________________________________Work Phone (____)__________________ SSN#______________________________

How did you hear about our Office:

____Advertising *(where)*______________________ **____Friend/Family (whom may we thank)_______________________________**

AS A COURTESY WE WILL BILL YOUR DENTAL *INSURANCE FOR YOU.*

YOUR PORTION IS DUE AT TIME OF SERVICE.

Section III **DENTAL Insurance Information**

Name of Insured____________________________________ DOB __________Relationship to Patient _______________________

SSN#: ____________________ Name of Employer: ______________________________Work Phone: (____) ___________________

Address of Employer: ____ City: _________________ State: _____ Zip __________

Insurance Company ______________________________________ Group # ______________ ID# ____________________________

***** DO YOU HAVE ANY **ADDITIONAL DENTAL INSURANCE?** ☐ **Yes** ☐ No **IF YES, COMPLETE THE FOLLOWING** *****

Name of Insured____________________________________ DOB __________Relationship to Patient _______________________

SSN#: ____________________ Name of Employer: ______________________________Work Phone: (____) ___________________

Address of Employer: ____ City: _________________ State: _____ Zip __________

Insurance Company ______________________________________ Group # ______________ ID# ____________________________

ASSIGNMENT AND RELEASE

I assign directly to Dr. Anderson all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. In the event the Patient or Guarantor defaults in payment, they agree to pay collection costs on accounts of 45% on the outstanding principal balance. In addition I agree to pay all court cost and reasonable attorney fees.

Dr. Anderson may use my health care information and may disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

____ ____

Signature of Patient, Parent, Guardian or Personal Representative — Printed name of Patient, Parent, Guardian or Personal Representative

____ ____

Relationship to Patient — Date

Health History

Family Doctor: ______________________ Date of last visit: __________ Pharmacy: ____________________
Cardiologist: __________________________ Orthopedic Surgeon: ______________________________

Dental History

Former Dentist: ____________________

Date of last dental x-rays: ______________

Date of last cleaning: _________________

Check yes or no if you have had or do have any of the following:

- Cigarette, pipe or cigar smoking ☐ Yes ☐ No
- Chew Tobacco ☐ Yes ☐ No
- Dry Mouth ☐ Yes ☐ No
- Gum Chewing ☐ Yes ☐ No
- Pop Drinker ☐ Yes ☐ No
- Fingernail Biting ☐ Yes ☐ No
- History of Periodontal Treatment ☐ Yes ☐ No
- Clinch/Grind Teeth ☐ Yes ☐ No

Are you interested in bleaching your teeth? ☐ Yes ☐ No

Allergies

- ☐ Codeine
- ☐ **Latex**
- ☐ **Penicillin**
- ☐ Iodine
- ☐ Local Anesthesia
- ☐ Sulfa
- ☐ Other ______________________

____

Check yes or no if you have had or do have any of the following:

- Acid Reflux ☐ Yes ☐ No
- Aids/HIV ☐ Yes ☐ No
- Anemia ☐ Yes ☐ No
- Arthritis, Rheumatism ☐ Yes ☐ No
- Arthritis, (Rheumatoid) ☐ Yes ☐ No
- **Artificial Heart Valves** ☐ Yes ☐ No
- **Artificial Joints** ☐ Yes ☐ No
  - What? ______________
  - **When** ______________
- Asthma ☐ Yes ☐ No
- Back Problems ☐ Yes ☐ No
- Bleeding abnormally, with Extractions or surgery ☐ Yes ☐ No
- Blood Disease ☐ Yes ☐ No
- Cancer ☐ Yes ☐ No
- ***Chemical Dependency** ☐ Yes ☐ No
- **Chemotherapy** ☐ Yes ☐ No
- Congenital Heart Lesions ☐ Yes ☐ No
- Cortisone Treatments ☐ Yes ☐ No
- Cough, persistent or bloody ☐ Yes ☐ No
- Diabetes ☐ Yes ☐ No
- Emphysema ☐ Yes ☐ No
- Epilepsy/Seizures ☐ Yes ☐ No
- Fainting or dizziness ☐ Yes ☐ No
- Glaucoma ☐ Yes ☐ No
- Headaches ☐ Yes ☐ No
- **Heart Murmur** ☐ Yes ☐ No
- **Heart Problems** ☐ Yes ☐ No
- Hepatitis Type _____ ☐ Yes ☐ No
- Herpes ☐ Yes ☐ No
- High Blood Pressure ☐ Yes ☐ No
- Jaundice ☐ Yes ☐ No
- Jaw Pain ☐ Yes ☐ No
- Kidney Disease ☐ Yes ☐ No
- Liver Disease ☐ Yes ☐ No
- Low Blood Pressure ☐ Yes ☐ No
- Lupus ☐ Yes ☐ No
- **Mitral Valve Prolapse** ☐ Yes ☐ No
- **Osteoporosis** ☐ Yes ☐ No
- Pacemaker ☐ Yes ☐ No
- Psychiatric Care ☐ Yes ☐ No
- **Radiation Treatment** ☐ Yes ☐ No
- ***Recreational Drugs** ☐ Yes ☐ No
- Respiratory Disease ☐ Yes ☐ No
- Rheumatic Fever ☐ Yes ☐ No
- Scarlet Fever ☐ Yes ☐ No
- Shortness of Breath ☐ Yes ☐ No
- Sinus Trouble ☐ Yes ☐ No
- Stroke ☐ Yes ☐ No
- Swollen Neck Glands ☐ Yes ☐ No
- Thyroid Problems ☐ Yes ☐ No
- Tuberculosis ☐ Yes ☐ No
- Tumor or growth on head or Neck ☐ Yes ☐ No
- Ulcer ☐ Yes ☐ No
- Weight Loss, unexplained ☐ Yes ☐ No

Women:

- Are you pregnant? ☐ Yes ☐ No
- Due Date __________
- Are you nursing? ☐ Yes ☐ No
- Taking Birth control pills? ☐ Yes ☐ No

Medications

List any medications you are currently taking and the correlating diagnosis:

____

____

____

****Recreational drugs used with local anesthesia can be deadly.***

Initial ________

Have you ever taken any sort of bisphosphonates for osteoporosis?

***Actenol*-When/ how long?**_

***Boniva* When/ how long?**

***Fosamax* When/ how long?**

***Generic*- When/ how long?**

Are you on any blood thinners?
(Examples: Aspirin, Coumadin, Warfarin, Plavix)
☐ Yes ☐ No

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement

I, ________________________, have received a copy or had an opportunity to read this office's Notice of Privacy Practices.

______________________ ______________________ ______________________

Please print name Signature Date

FOR OFFICE USE ONLY: 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 ☐ An emergency situation ☐ Other______________________