ANDERSON
FAMILY DENTISTRY

Patient Name: _____ Date of birth: _____

Address: _____ Home phone: _____

_____ Work phone: _____

Email: _____ Cell phone: _____

Preferred contact method: Home phone _____Work phone _____ Cell phone _____ Email _____

SSN: _____ Occupation: _____

Spouse's name: _____ Occupation: _____

Person responsible for account: _____ Date of birth: _____

SSN: _____

Primary Dental Insurance:

Employer: _____ Address: _____

_____

Insurance company: _____ Address: _____

Group Number: _____ _____

Member ID number (if applicable): _____

Secondary Dental Insurance:

Employer: _____ Address: _____

_____

Insurance company: _____ Address: _____

Group Number: _____ _____

Member ID number (if applicable): _____

How did you come to learn about our office? _____

Authorization, Release, and Agreement to pay for services rendered (please sign all three)

I agree to be responsible for payment of all services rendered on behalf of myself and my dependents. I authorize the dentist to release any information to third party payors, collection agencies, and/or other health practitioners as needed. This may include the diagnosis and records of any examination or treatment rendered.

x: _____ Date: _____

I authorize and hereby request my insurance company to pay, directly to the dentist, insurance benefits otherwise payable to me.

I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or on behalf of my dependents.

x: _____ Date: _____

Federal regulations require that we ask you to sign this acknowledgement of receipt of privacy practices. Good faith and reasonable effort will be made to allow for timely delivery of necessary healthcare while safeguarding patient privacy and complying with federal and state regulations. You have specific rights concerning your personal health information. The notice is posted in our office and you may request a printed copy.

You may refuse to sign this acknowledgement.

x: _____ Date: _____

_____ For Office Use Only _____

_____ Individual refused to sign

_____ Communication Barriers prohibited obtaining acknowledgement

_____ Emergency situation prohibited us from obtaining acknowledgement

_____ Other (specify) _____

Health Information

Please check which of the following you have had or have at the present.

__Heart Disease	___Heart Attack	__Asthma
__Heart Valve Replacement	__HIV/AIDS	__Latex Allergy
__Rheumatic Fever	__Hepatitis	___Thyroid Issues
__High Blood Pressure	__Liver Disease	__Diabetes
__Pacemaker	__Tuberculosis	__Radiation Treatments
__Stroke	__Dizziness/Fainting	__Osteoporosis
__Epilepsy	__Joint Replacement	__Cancer

Please list any other health concerns you think we should be aware of.

Please list any medications you are allergic to or have had adverse reactions to.

Do you currently use any type of tobacco products? Yes ____ No ____

If yes, what type?

Do you vape? Yes ____ No_____

For women: Please tell us if you are pregnant. Yes ____ No ____

Have you ever taken Fosamax or any other bisphosphonate drug? Yes ____ No ____

Please list all medications you are currently taking and reason for taking.

Dental History

Please list the name of your previous dentist and the date of your most recent exam if other than this office.

Do you have any immediate dental concerns? Yes ___ No____

If so, please tell us about them here:

Is there anything about the appearance of your teeth you would like to change?

Do you have a history of gum disease? Yes ___ No ____

How do you feel about dental treatment?

___no problem ___worry about it ___very fearful

Have you had any serious problems associated with dental treatment? Yes ___ No ____

Have you had any adverse reactions to dental anesthetic? Yes ___ No ____

If so, which one?

Have you had a history of difficulty getting numb? Yes ___ No ____