ANDERSON DENTAL

(605) 721-1219 · dental@rapidnet.com

We want to **WELCOME YOU TO OUR OFFICE …** The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out this form as completely as possible. The better we communicate, the better we can serve you.

Today's Date: _____ / _____ / _____

ABOUT YOU

First Name: _____ Middle Initial: _____ **Last**: _____ ☐ Male ☐ Female

Birth Date: ____ / ____ / ____ **Age:** _____ **SSN:** _____ ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Home Address: _____ City: _____ State: _____ Zip: _____

E-mail:_____ **For Apt. Reminders**: ☐ Call: H / C / W ☐ Text ☐ Email

Phone Number: (____)_____-_____ Employer: _____ Occupation: _____

Employers Address: _____ City: _____ State: _____ Zip: _____

Emergency Contact: _____ Relationship to Patient: _____

Address: _____ Phone: (_____) _____-_____

Responsible Party

Name: _____ Relationship to Patient: _____

SSN**:** _____ Birth Date: ____ / ____ / ____ Phone: (_____) _____-_____ ☐ Cell ☐ Home

Employer: _____ Work Phone: _____ ext: _____

Insurance / Self Pay

Self Pay: ☐ Cash ☐ Credit Card ☐ Care Credit **Driver's License #: _____**

Primary Dental Insurance Co.: _____ID:_____ Group #: _____

Phone: (_____) _____-_____ Address: _____ City: _____ State: _____ Zip:_____

Policy Holder's Name: _____ Relationship to Patient: _____ SSN: _____ DOB: ___ / ___ / ___

Secondary Dental Insurance Company: _____ Group #: _____

Phone: (_____) _____-_____ Address: _____ City: _____ State: _____ Zip:_____

Policy Holder's Name: _____ Relationship to Patient: _____ SSN: _____ DOB: ___ / ___ / ___

Policy Holder's Employer: _____ Address: _____

How did you hear about our office? ☐ Facebook ☐ Yellow Pages ☐ Website ☐ Friend ☐ Location/Sign
☐ Doctor _____ ☐ Patient _____ ☐ Other _____

***** Whom may we thank for referring you?** _____

Dental History

Are you currently in pain? ☐ Yes ☐ No
Your dental concerns? _____
_____
Do you suffer from dental anxiety? ☐ Yes ☐ No
Are you happy with your smile? ☐ Yes ☐ No
What would you like to change? _____
Have you experienced jaw pain or discomfort? ☐Yes ☐No
Date of last dentist visit: __ / __ /____

Do you have any of the following concerns? ☐ Bleeding Gums
☐ Hot/Cold Sensitivity ☐ Sensitivity to Sweets☐ Painful Biting
Use anything in addition to your brush & floss? ☐ Y ☐ N
If yes, what? _____
Do you require antibiotics before treatment?☐Yes ☐No
Due to: ☐☐ Artificial Joints ☐☐ Infective Endocarditis
☐☐ History of infection in heart valve
Other: _____

Medical History

Are you currently under the care of a Physician? ☐ Yes ☐ No
If yes, please explain: _____
Physician's Name_____
Address: _____
Phone #_____Date of last visit ___/___/___
For Women:
Are you taking birth control pills? ☐ Yes ☐ No
Are you pregnant? ☐ Unsure ☐ Yes ☐ No Week#_____
Are you Nursing? ☐ Yes ☐ No

Are you **allergic** to any of the following?

Yes No		Yes No	
☐ ☐	Aspirin	☐ ☐	Jewelry/Metals
☐ ☐	Antibiotics	☐ ☐	Latex
List all _____		☐ ☐	Sedatives
☐ ☐	Barbiturates	☐ ☐	Codeine
☐ ☐	Dental Anesthetics	☐ ☐	Lactose

Please list additional allergies _____

Are you taking any of the following medications / drugs?

Yes No		Yes No		Yes No		Yes No	
☐☐	Acetaminophen (Tylenol)	☐☐	Blood Thinners	☐☐	Insulin /Diabetic drugs	☐☐	Steroids / Cortisone
☐☐	Antibiotics	☐☐	Blood Pressure Med	☐☐	Naproxen (Aleve)	☐☐	Thyroid Medicine
☐☐	Antihistamines	☐☐	Digitalis/Heart med	☐☐	Recreational Drugs	☐☐	Tranquilizers
☐ ☐	Antidepressants	☐☐	Ibuprofen	☐☐	Nitroglycerin	☐☐	Bisphosphonates, bone medications or shots
☐☐	Aspirin	☐☐	Other				

(please list all medications) _____
_____
_____

Do you or have you experienced the following?

Y N		Y N		Y N		Y N		Y N	
☐☐	Abnormal Bleeding	☐ ☐	Chemotherapy	☐☐	Heart Attack	☐☐	Migraines	☐☐	Sinus Problems
☐☐	Acid Reflux/GERD	☐ ☐	Colitis	☐☐	Heart Murmur	☐☐	Oral Herpes/Cold Sore	☐☐	Smoke/ Chew/ Vape
☐☐	Alcohol Abuse	☐☐	Congenital Heart Defect	☐☐	Heart Surgery	☐☐	Pacemaker	☐☐	Steroid Therapy
☐☐	Anemia	☐☐	Diabetes	☐☐	Hemophilia	☐☐	Psychiatric Problems	☐☐	Stroke
☐☐	Arthritis	☐☐	Difficulty Breathing	☐☐	Hepatitis _____	☐☐	Radiation Treatment	☐☐	Tonsillitis
☐☐	Asthma	☐☐	Drug Abuse	☐☐	HIV+/Aids	☐☐	Seasonal Allergies	☐☐	Tuberculosis (TB)
☐☐	Blood pressure high	☐☐	Epilepsy	☐☐	Joint replacement	☐☐	Seizures	☐☐	Ulcers
☐☐	Blood pressure low	☐ ☐	Fainting Spells	☐☐	Kidney Problem	☐☐	Sickle Cell Disease		
☐☐	Blood Transfusion	☐ ☐	Fever blisters	☐☐	Liver Disease	☐☐	Recent Surgeries (please list) _____		
☐☐	Cancer_____	☐ ☐	Frequent Headaches	☐ ☐	Lupus				

Authorizations

I affirm that the information I have given is correct to the best of my knowledge, it will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary dental services I may need. I hereby authorize the dentist to release all information necessary to secure the payment of benefits.
I understand that I am ultimately responsible for payment of services rendered and for payment of any co-pay and deductible that my insurance does not cover.

Signature: _____ Date: _____