Welcome….

The benefits of a happy, health 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.

Dr. Kurt Anderson & Staff

About You

Name: ______________________________ ☐Male ☐Female

Birth Date: ___/___/______ Age: ____ SSN: ______________ ☐Single ☐Married ☐Divorced ☐Widowed

Home Address: ______________________________

Home Phone: ( )______________ Cell: ( )______________ Work: ( )______________ext. _____

When & where is the best time to reach you? ______________________________

Employer: ______________________ Occupation: ______________________

Employers Address: ______________________________

Emergency contact person: ______________________Relationship ______________

Address: ______________________________Phone: ( )______________

Person responsible for account: ______________________ Relationship ______________

Address: ______________________________Phone: ( )______________

Your Spouse

Name: ______________________ SSN:______________ Birth Date:___/___/______

Employer: ______________________ Work Phone: ( )______________ext._____

Insurance

Primary Dental Insurance Company: ______________________________

Phone: ( )______________ Group/Plan: ______________

Address: ______________________________

Policy Holders Name: ______________________ SSN: ______________ DOB: ___/___/______

Policy Holders Employer/Address: ______________________________

Secondary Dental Insurance Company:______________________ Phone: ( )______________

Address: ______________________ Group/Plan: ______________

Policy Holders Name: ______________________ SSN: ______________ DOB: ___/___/______

Policy Holders Employer/Address: ______________________________

How did you hear about our office? ☐Radio/TV ☐Yellow Pages ☐Website ☐Friend ☐Other______________

Whom may we thank for referring you? ______________________________

Dental History

Are you currently in pain? ☐Yes ☐No
What are your dental concerns:______________________________

Are you happy with your smile: Up close? ☐Yes ☐No
In pictures? ☐Yes ☐No
What would you like to change? ______________________________

Do you now or have you ever experienced pain/discomfort in your jaw joint? ☐Yes ☐No

Do you suffer from frequent headaches/Migraines? ☐Yes ☐No

Do you have any of the following concerns?
☐ Hot/Cold Sensitivity ☐ Sensitivity to Sweets
☐ Painful Biting ☐ Bleeding Gums

Do you use anything in addition to your brush & floss? ☐Yes ☐No
If yes, what? ______________________________

Do you still have wisdom teeth? ☐Yes ☐No
Date of last dentist visit: ____/____/_______

Do you require antibiotics before dental treatment? ☐Yes ☐No
Due to:
☐Artificial Joints ☐Artificial Valves ☐Mitral Valve Prolapse
☐Scarlet Fever ☐Rheumatic Fever ☐Heart Surgery
☐Immunodeficiency

Medical History

Do you have a personal physician? ☐Yes ☐No
Physicians name: ______________________________
Address: ______________________________
Phone#:_______________ Date of last visit: ___/___/______
Are you currently under the care of a Physician? ☐Yes ☐No
If yes, please explain:______________________________

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	☐	☐	Erythromycin
☐	☐	Sedatives	☐	☐	Barbiturates
☐	☐	Jewelry/Metals	☐	☐	Sulfa Drugs
☐	☐	Codeine	☐	☐	Latex
☐	☐	Tetracycline	☐	☐	Dental Anesthetics
☐	☐	Seasonal Allergies	☐	☐	Penicillin
☐	☐	Food Allergies	☐	☐	Other

Please list additional drugs/materials that cause allergic reactions: ______________________________

Are you taking any of the following medications?

Y	N		Y	N		Y	N		Y	N	
☐	☐	Acetaminophen	☐	☐	Blood Thinners	☐	☐	Insulin/Diabetic drugs	☐	☐	Thyroid Medicine
☐	☐	Antibiotics	☐	☐	Blood Pressure Med	☐	☐	Nitroglycerin	☐	☐	Tranquilizers
☐	☐	Antihistamines	☐	☐	Recreational Drugs	☐	☐	Ibuprofen	☐	☐	Naproxen
☐	☐	Aspirin	☐	☐	Digitalis/Heart Med	☐	☐	Steroids/Cortisone	☐	☐	Antidepressants

Do you or have you experienced the following?

Y	N		Y	N		Y	N		Y	N		Y	N	
☐	☐	Abnormal Bleeding	☐	☐	Colitis	☐	☐	Heart Attack	☐	☐	Lupus	☐	☐	Seizures
☐	☐	Alcohol Abuse	☐	☐	Congenital Heart Defect	☐	☐	Heart Murmur	☐	☐	Migraines	☐	☐	Sickle Cell Disease
☐	☐	Anemia	☐	☐	Diabetes	☐	☐	Heart Surgery	☐	☐	Mitral Valve Prolapse	☐	☐	Sinus Problems
☐	☐	Arthritis	☐	☐	Difficulty Breathing	☐	☐	Hemophilia	☐	☐	Oral Herpes/Cold Sores	☐	☐	Steroid Therapy
☐	☐	Artificial Bones/Joints	☐	☐	Drug Abuse	☐	☐	Hepatitis	☐	☐	Pacemaker	☐	☐	Stroke
☐	☐	Asthma	☐	☐	Epilepsy	☐	☐	HIV+/AIDS	☐	☐	Psychiatric Problems	☐	☐	Tonsillitis
☐	☐	Blood Transfusion	☐	☐	Fainting Spells	☐	☐	Kidney Problems	☐	☐	Radiation Treatment	☐	☐	Tuberculosis (TB)
☐	☐	Cancer	☐	☐	Fever Blisters	☐	☐	Liver Disease	☐	☐	Rheumatic Fever	☐	☐	Ulcers
☐	☐	Chemotherapy	☐	☐	Frequent Headaches	☐	☐	Low Blood Pressure	☐	☐	Scarlet Fever	☐	☐	Venereal Disease

Please list any serious medical conditions(s) that you have experienced / Handicaps or Disabilities: ______________________________

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 also certify that I am covered by______________________________Insurance Company and I assign directly to the Center for Dental Excellence all insurance benefits, otherwise payable to me. 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. I authorize the use of this signature on all my insurance submissions, whether manual or electronic. **I also agree that should this account become delinquent and registered with an outside collection agency an additional fee of 45% of the unpaid balance shall be assessed.**

Signature ______________________________Date: ______________________________.