Anderson Orthodontics

Patient Registration and Health History - Adult

1 About You

Name: _____

Preferred Name: _____

Age: _____ □ Male □ Female

Birthdate: (mo/day/yr) ____/____/_____

Home Phone: _____

Other Phone: _____

Home Address: _____

_____

□ Single □ Married □ Divorced □ Widowed

Other family members seen by us: _____

Who may we thank for referring you: _____

2 Account Information

Name: _____

Relation: _____

Birthdate:_____/_____/_____ SS #:_____

Occupation: _____

Employer: _____

Business Phone: _____

SPOUSE:

Name: _____

Birthdate:____/____/_____SS #: _____

Occupation: _____

Employer: _____

Business Phone: _____

Emergency Contact: _____

Relation: _____ Phone: _____

3 Dental Insurance

Policy Holder: _____ Relation: _____

Insurance Co: _____

Insurance Address: _____

Insurance Phone #: _____

Ins.ID #: _____

Group #: _____

Insured's Birthdate:____/____/_____

Insured's SS#: _____

Insured's Employer: _____

I hereby authorize payment of the dental benefits, otherwise payable to me, directly to Dr. Eric Anderson DMD. I understand I am responsible for any charges not covered by my insurance company.

_____

Subscriber signature Date

4 Privacy Consent

The information that I have given today is correct to the best of my knowledge. This information is used in our office as part of the treatment process. It can also be shared with providers outside the office under the following circumstances:

Information required for receiving dental benefits will be shared with the insurance company.

Information regarding treatment may be shared with the patient's dental provider. This information is limited to treatment and may include treatment summaries, photos and radiographs.

_____

Signature Date

5 Health History

	Yes	No
Are you being treated by a physician at this time?	❑	❑
Have you ever been hospitalized?	❑	❑
Do you have any allergies: _____	❑	❑
Are you taking any medications: _____	❑	❑
Are you Pregnant	❑	❑

Have you ever been diagnosed as having any of the following conditions?

	Yes	No		Yes	No
Arthritis	❑	❑	Heart Disease/Attacks	❑	❑
High Blood Pressure	❑	❑	Joint Replacement	❑	❑
Asthma	❑	❑	Hepatitis	❑	❑
Bleeding Problems	❑	❑	HIV or AIDS	❑	❑
Stroke	❑	❑	Radiation Therapy	❑	❑
Cancer	❑	❑	Liver Disease	❑	❑
Cleft Lip/Palate	❑	❑	Vision/Hearing Issues	❑	❑
Diabetes	❑	❑	Heart Conditions	❑	❑
Epilepsy	❑	❑	Other _____		

6 Dental History

Dentist_____ Date of Last Visit_____

How often do you brush per day:	❑ 1X	❑ 2X	❑ 3X	❑ 4+
Do you floss?	❑ Yes	❑ No		
Do your gums bleed?	❑ Yes	❑ No		
Are your teeth sensitive to hot/cold?	❑ Yes	❑ No		
Any joint issues	❑ Yes	❑ No		
Have you had orthodontics before?	❑ Yes	❑ No		
Any difficulty chewing	❑ Yes	❑ No		

Areas of Concern (Circle all that apply):

Crowding	Missing/Extra teeth	Cross-bite	Speech Problems
Spacing	Overbite	Late Eruption	Jaw Problems

History of the following (Circle all that apply):

Trauma to Teeth/Face	Mouth breathing	Snoring	Tongue Thrust
Grinding/Clenching	Headaches/Earaches	Previous orthodontic treatment	

_____ _____ _____

Patient Signature Date Doctor Signature