

HEALTH HISTORY

	Yes	No
Are you under medical treatment now?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>
Are you taking any medications?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, List _____		
Do you have any allergies?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, List _____		
Do you use tobacco?	<input type="checkbox"/>	<input type="checkbox"/>
Are you pregnant?	<input type="checkbox"/>	<input type="checkbox"/>

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

	Yes	No		Yes	No
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>	HIV or AIDS	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Joint Replacement	<input type="checkbox"/>	<input type="checkbox"/>
Cleft Lip/Palate	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Therapy	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Vision/Hearing Issues	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease/Attacks	<input type="checkbox"/>	<input type="checkbox"/>	Other _____		

DENTAL HISTORY

Dentist _____ Date of Last Visit _____

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

Areas of Concern (Circle all that apply):

Crowding	Missing/Extra teeth	Cross-bite	Speech Problems
Crooked Teeth	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	

Is there anything we should know about you?

Signature

Date

Doctor Signature

ABOUT YOU

Name: _____

Birthdate: ___/___/____ Male Female

Married Single Divorced Widowed

SSN: _____

Home Address: _____

Employer: _____

City: _____ St: _____ Zip: _____

Occupation: _____

Phone: () _____ Home Cell

Employer Address: _____

Email: _____

Work Phone : () _____ Ext: _____

How did you hear about us: _____

Emergency Contact: _____

Other family members seen by us: _____

Relation: _____ Phone: () _____

SPOUSE INFORMATION

Name: _____

Birthdate: ___/___/____

Phone: () _____ Home Cell

Work Phone : () _____ Ext: _____

Employer: _____

Occupation: _____

ACCOUNT INFORMATION

Name: _____

Relation to patient: _____

Birthdate: ___/___/____

Married Single Divorced Widowed

Phone: () _____ Home Cell

Work Phone: _____

Employer: _____

Occupation: _____

DENTAL INSURANCE

Policy Holder: _____

Relation to patient: _____

Policy holder Birthdate: ___/___/____

Policy holder Employer: _____

Insurance Company: _____

Insurance Phone: _____

ID# : _____ SSN: _____

Group #: _____

I hereby authorize payment directly to Dr. Eric Anderson DMD, unless otherwise stated. I understand I am responsible for any charges not covered by my insurance company.

Signature

_____/_____/_____
Date

CONSENT

I consent to records to be taken as part of the consult process. These may include radiographs and photos. This information is used in our office as part of the treatment process. It can also be used to communicate with other providers or insurance companies.

Signature

_____/_____/_____
Date