Anderson Dental
& IMPLANT CENTER

Ross W. Anderson, D.D.S., P.A.
Fellow Academy of General Dentistry

Patient Information

Patient Name: _____ ☐ Male ☐ Female
First MI Last

☐ Married ☐ Single ☐ Child ☐ Other _____ Birth Date: _____ Age: _____

Social Security #: _____

Spouse's Name: _____ Work# _____ Cell# _____

Phone (Home) _____ ___ (Cell) _____ E-Mail Address _____

Home Address: _____
Street City State Zip Code

Name of Employer: _____ (Work#) _____ Ext: _____

If Minor, Mother's Name: _____ Home Ph# _____ Cell _____

Name of Employer _____ Work# _____ Ext _____

If Minor, Father's Name: _____ Home Ph# _____ Cell _____

Name of Employer _____ Work# _____ Ext _____

Dental Insurance Information

Name of Insurance Company: _____ Policy # _____ Group # _____

Insurance Provider: ☐ Individual ☐ Employer If Employer, Name of Company _____

Policy Holders Name: _____ SSN _____ Date of Birth _____

Medical Insurance Information

Name of Insurance Company: _____ Policy # _____ Group # _____

Insurance Provider: ☐ Individual ☐ Employer If Employer, Name of Company _____

Policy Holders Name: _____ SSN _____ Date of Birth _____

Reason for today's Visit _____

Previous Dentist _____ Date of last dental visit _____ Date of last dental x-rays _____

Physician Name _____ Physician Phone # _____

Are you under a physician's care now? ***Yes / No*** If yes, explain: _____
Have you ever been hospitalized or had a major operation? ***Yes / No*** If yes, explain: _____
Have you ever had a serious head or neck injury? ***Yes / No*** If yes, explain: _____
Are you taking any over the counter medication? ***Yes / No*** If yes, explain _____
Are you on a special diet? ***Yes No*** If yes, explain _____
Do you use tobacco? ***Yes / No***
Do you use a CPAP ***Yes / No*** If yes, explain _____
Do you snore? ***Yes / No***
Women: Are you pregnant/Trying to get pregnant ***Yes / No*** If yes, due date _____
Nursing? ***Yes / No***
Taking oral contraceptive ***Yes / No***

Indicate if you have, or have you had, any of the following?

Anderson Dental
& IMPLANT CENTER

Ross W. Anderson, D.D.S., P.A.
Fellow Academy of General Dentistry

Bad Breath	Yes / No	Alzheimer's Disease	Yes / No	Epilepsy or Seizures	Yes / No	Lung Disease	Yes / No
Bleeding Gums	Yes / No	Anaphylaxis	Yes / No	Excessive Bleeding	Yes / No	Malignant Hyperthermia	Yes / No
Burning Sensation On tongue	Yes / No	Anemia	Yes / No	Excessive Thirst	Yes / No	Mitral Valve Prolapsed	Yes / No
Chew on one side Of mouth	Yes / No	Angina	Yes / No	Fainting spells / Dizziness	Yes / No	Pain in Jaw Joints	Yes / No
Clicking or popping Jaw	Yes / No	Arthritis / Goul	Yes / No	Frequent Cough	Yes / No	Parathyroid Disease	Yes / No
Dry mouth	Yes / No	Artificial heart Valve	Yes / No	Frequent Diarrhea	Yes / No	Psychiatric Care	Yes / No
Fingernail Biting	Yes / No	Artificial Join	Yes / No	Frequent Headaches	Yes / No	Radiation Treatments	Yes / No
Food collection between Teeth	Yes / No	Asthma	Yes / No	Gas- Reflux Disease	Yes / No	Recent Weight Loss	Yes / No
Foreign objects	Yes / No	Back problems	Yes / No	Genital Herpes	Yes / No	Renal Dialysis	Yes / No
Grinding teeth	Yes / No	Blood Disease	Yes / No	Glaucoma	Yes / No	Rheumatic Fever	Yes / No
Gums swollen or Tender	Yes / No	Blood Transfusion	Yes / No	Hay Fever	Yes / No	Rheumatism	Yes / No
Jaw pain or Tiredness	Yes / No	Breathing Problem	Yes / No	Head injuries	Yes / No	Scarlet Fever	Yes / No
Lip or cheek Biting	Yes / No	Bruise Easily	Yes / No	Heart attack / Failure	Yes / No	Shingles	Yes / No
Loose teeth or Broken Fillings	Yes / No	Cancer	Yes / No	Heart murmur	Yes / No	Shortness of Breath	Yes / No
Mouth Breathing	Yes / No	Chemical Dependency	Yes / No	Heart Pacemaker	Yes / No	Sickle Cell Disease	Yes / No
Mouth pain, Brushing	Yes / No	Chemotherapy	Yes / No	Heart Trouble / Disease	Yes / No	Sinus Trouble	Yes / No
Orthodontic Treatment	Yes / No	Chest pains	Yes / No	Hemophilia	Yes / No	Sleep Trouble	Yes / No
Pain around Ear	Yes / No	Cholesterol	Yes / No	Hepatitis A B, C	Yes / No	Spina Bifida	Yes / No
Periodontal Treatment	Yes / No	Circulatory Problems	Yes / No	Herpes	Yes / No	Stomach / Intestinal Disease	Yes / No
Sensitivity to Cold	Yes / No	Congenital Heart Disorder	Yes / No	High Blood Pressure	Yes / No	Stroke	Yes / No
Sensitivity to Hot	Yes / No	Convulsions	Yes / No	Hives or Rash	Yes / No	Swelling of limbs, Feet	Yes / No
Sensitivity to Sweets	Yes / No	Cortisone Medicine	Yes / No	Hypoglycemia	Yes / No	Thyroid Disease	Yes / No
Sensitivity when Biting	Yes / No	Cough Problems	Yes / No	Irregular Heartbeat	Yes / No	Tonsillitis	Yes / No
Sores or growth In your mouth	Yes / No	Diabetes	Yes / No	Kidney Problems	Yes / No	Tuberculosis	Yes /No
How often do You brush?		Drug Addiction	Yes / No	Leukemia	Yes / No	Tumors or Growths	Yes / No
How often do You floss?		Easily Winded	Yes / No	Liver Disease	Yes / No	Ulcers	Yes / No
AIDS/HIV Positive	Yes / No	Emphysema	Yes / No	Low Blood Pressure	Yes / No	Venereal Disease	Yes / No

Anderson Dental
& IMPLANT CENTER

Ross W. Anderson, D.D.S., P.A.
Fellow Academy of General Dentistry

MEDICATIONS

List any medications you are currently taking and correlating diagnosis:

Name	Dosage	How Taken

Pharmacy Name:_____
Phone #:_____

ALLERGIES

- ○ None
- ○ Aspirin
- ○ Barbiturates (sleeping pills)
- ○ Codeine
- ○ Iodine
- ○ Latex
- ○ Local Anesthetic
- ○ Penicillin
- ○ Sulfa
- ○ Other _____

What are the reactions? _____

Referral Information

Whom may we thank for referring you to our practice? ☐Another patient, friend ☐Another patient, relative

☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other_____

Name of person or office referring you to our practice:_____

Contact Information

Person and phone numbers to contact in case of an emergency:_____

Other person and phone numbers to contact other than emergency contact:_____

Authorization

I consent to treatment by Dr. Ross W. Anderson and assistants. I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group 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 my dependents.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____
Signature of patient, parent or guardian

_____ Date: _____
Signature of guarantor of payment/responsible party