WELCOME

David E. Andersen, D.D.S., P.A.

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1 About You

Today's Date: _____

Name: _____
LAST FIRST MI

I prefer to be called: _____ ☐ Male ☐ Female

Birthdate: ___/___/___ Age: _____ SS #: _____

Home Address: _____
NO P.O. BOXES PLEASE APT/CONDO #

_____
COUNTY CITY STATE ZIP

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Preferred method of communication: ☐ Cell ☐ *Text ☐ Email
*Standard text fees apply

Hm Phone #: _____ Wk #: _____ Ext _____

Cell #: _____ Cell Provider: _____

Where & when are best times to reach you? _____

Email Address: _____

Employer: _____

Employer's Address: _____

Occupation: _____ Years of service _____

2 Spouse Information

Their Name: _____

Employer: _____

Wk #: _____ Ext _____

Birthdate: _____

3 Person Responsible for Account

Name: _____

Wk #: _____ Ext _____ Hm #: _____

Billing Address: _____
Zip

Relationship: _____ SS #: _____

Employer: _____

Emergency contact

Their Name: _____

Phone #: _____

4 Dental Insurance

Primary Dental Insurance
(Please present insurance card upon check-in.)

Insurance Co. Name: _____

Subscriber ID #: _____

Group # (or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthday: ___/___/___ Insured's SS #: _____

Insured's Employer: _____

Do you have a secondary dental insurance plan? ☐ No ☐ Yes

We submit insurance as a courtesy for our patients. You are responsible for being fully aware of the terms/limits of your policy.

5 Dental History

What is the reason for your visit today? _____

_____

_____

Are you currently in pain? ☐ No ☐ Yes

Select the one which best describes how you feel about your oral health.

☐ I take great pride of my teeth

☐ I only want necessary treatment performed

☐ I only want minimal treatment ie, a filling instead of a crown

☐ I do not want any tooth discomfort

Have you ever had a problem associated with previous dental work? ☐ No ☐ Yes

Do you feel nervous about having dental treatment? ☐ No ☐ Yes

Have you ever experienced pain / discomfort in your jaw joint? ☐ No ☐ Yes

Do you clench or grind your teeth? ☐ No ☐ Yes

Do your gums ever bleed? ☐ No ☐ Yes

Have you had a history of gum disease? ☐ No ☐ Yes

How often do you see a dentist for routine cleaning and exam?

_____

Do you brush and floss daily? _____

Previous / Present Dentist: _____
(Please Circle) CITY/STATE

Last Visit Date: _____

CONTINUED ON BACK OF FORM

6 Medical History

Do you have a personal physician? ☐ No ☐ Yes

Physician's Name: _____

Phone #: _____ Date of last visit: _____

Your current physical health is: ☐ Good ☐ Fair ☐ Poor

Are you currently under the care of a physician? ☐ No ☐ Yes

Please explain _____

Are you taking any prescription/over-the-counter drugs, vitamins, or herbal supplements? ☐ No ☐ Yes

Please list each one or provide a list if available _____

_____

Pharmacy preference _____

Have you ever had to take an antibiotic before a dental appointment in the past?
☐ No ☐ Yes If yes, please specify why _____

Have you ever had any of the following diseases or medical problems? Please circle all conditions that apply.

Y N Hyper- or Hypo-Thyroidism	Y N Hemophilia / Abnormal Bleeding
Y N High Cholesterol	Y N Epilepsy / Seizures / Fainting Spells
Y N Heart Attack	Y N Ulcers / Colitis
Y N Stroke	Y N Anemia / Radiation Treatment
Y N Cancer / Chemotherapy	Y N Asthma
Y N Heart Murmur	Y N Arthritis
Y N HIV+ / AIDS	Y N Difficulty Breathing
Y N Heart Surgery / Pacemaker	Y N Hepatitis Type:_____
Y N Shingles	Y N Blood Transfusion
Y N Kidney Problems	Y N Emphysema
Y N Sinus Problems	Y N Glaucoma
Y N High Blood Pressure	Y N Use Chewing Tobacco
Y N Low Blood Pressure	Y N Have you ever taken prescription weight reduction drugs?
Y N Fever Blisters / Cold Sores	
Y N Severe / Frequent Headaches	Y N Have you ever taken osteoporosis meds?
Y N Do you smoke?	
Y N History of opiods use	Y N Do you wear hearing aids?
Y N Psychiatric Problems	Y N Cocaine Use
Y N Congestive Heart Failure	Y N Rheumatic Fever*
Y N Diabetes	Y N Mitral Valve Prolapse*
Y N Tuberculosis (TB)	Y N Artificial Bones / Joints
Y N Drug / Alcohol Abuse	Y N Artificial Valves*
Y N Venereal Disease	Y N Congenital Heart Defect*

***Indicates antibiotic premedication may be required prior to your appointment.**

Do you have a Family History of:

Y N Diabetes	Y N Cardiovascular Disease
Y N High Blood Pressure	Y N High Cholesterol or Stroke

For Women Are you taking birth control pills? ☐ No ☐ Yes

Are you pregnant? ☐ No ☐ Yes Week # _____

Are you nursing? ☐ No ☐ Yes

6 Medical History continued

Please list any serious medical condition(s) that you have ever had:

_____

_____

Are you allergic to any of the following drugs?

Y N Penicillin	Y N Tetracycline	Y N Latex
Y N Aspirin	Y N Dental Anesthetics	Y N Sulfa
Y N Erythromycin	Y N Codeine	

Please list any other drugs that you are allergic to: _____

_____

HIPAA:
I acknowledge that I received/read a copy of David E. Andersen, D.D.S., P.A. Notice of Privacy Practices.

_____
Signature Date

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information 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 any necessary dental services with my informed consent that I may need during diagnosis and treatment.**

I agree to be responsible for all charges not paid by my dental benefit plan. I authorize the release of any information relating to each dental claim as necessary. Additionally, I authorize payment of dental benefits otherwise payable to me to be paid directly to this office.

_____
Signature Date

Payment is due in full at the time of treatment unless prior arrangements have been approved.

Thank you for filling out this form completely. It will enable us to help you more effectively. If you have any questions at any time, please ask us. We are happy to help.

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

Personnel Use Only

MEDICAL HISTORY UPDATE

1. Date _____ Comments _____ Signature _____
2. Date _____ Comments _____ Signature _____
3. Date _____ Comments _____ Signature _____
4. Date _____ Comments _____ Signature _____
5. Date _____ Comments _____ Signature _____
6. Date _____ Comments _____ Signature _____

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