Scott Anderson DDS

2535 Galen Drive Champaign, Illinois Ph: 217.356.7334

scottandersonsmiles.com

Welcome to Our Office

Please complete the following information so that we may better serve you.

Date: ______________ Referred by: ______________

PATIENT INFORMATION

Title: Mr. Mrs. Ms. Miss Dr. Name: ______________ ☐ Male ☐ Female

Name I prefer to be called: ______________ Birthdate: ______________

Street Address, City, State, Zip ______________

Home Phone: ______________ Work Phone: ______________ Cell Phone: ______________

E-mail Address: ______________ Social Security #: ______ - ______ - ______

Employer: ______________

Employer's Address, City, State, Zip: ______________

How do you prefer to be contacted for appointment reminders?

Email ______________ Text ______________ Phone Call ______________

DENTAL INSURANCE INFORMATION (If applicable)

Insured's Name: ______________ Insured's S.S. #: ______ - ______ - ______

Member ID # ______________

Policy and/or Group #: ______________ Insured's Date of Birth: ______________

Dental Insurance Company Name: ______________

Dental Insurance Co. Address: ______________

Dental Insurance Co. Phone: ______________

Do You Have Dual Coverage? YES NO Secondary Insurance Company: ______________

EMERGENCY NOTIFICATION INFORMATION

Primary Care Physician: ______________ Phone: ______________

In case of emergency, who should be notified?

Name: ______________ Address: ______________

Phone: ______________ Relationship to Patient: ______________

Are you in good health? ❑ Yes ❑ No Last Physical or Checkup: ______________________

Do you have, or have you had, any of the following? (Please circle all that apply)

Heart Disease	Epilepsy	Tuberculosis
Mitral Valve Prolapse	Arthritis	AIDS
High Blood Pressure	Cancer History	Hepatitis
Low Blood Pressure	Asthma	Thyroid conditions
Stroke	Liver Disease	Frequent Cold Sores
Pacemaker	Kidney Disease	Artificial Joints
Heart Valve Implants	Recent Cough	Diabetes
Heart Murmur	Rheumatic Fever	Anemia

Do you have any existing illnesses? ❑ Yes ❑ No (If yes, please explain) ______________________

____

Do you use any tobacco in any form? ❑ Yes ❑ No ______________________

Do you have any allergies? ❑ Yes ❑ No ______________________

Are you pregnant? ❑ Yes ❑ No

Have you been hospitalized in the last two years? ❑ Yes ❑ No ______________________

Do you have artificial joints or heart valves? ❑ Yes ❑ No ______________________

Are you taking any medications? If yes, please list ______________________

Do you have a history of bleeding excessively after being cut or injured? ❑ Yes ❑ No

Are there any other conditions concerning your health that we should be aware of? ❑ Yes ❑ No

Has your physician told you to premedicate with antibiotics prior to dental appointments? ❑ Yes ❑ No

Dental Information:

Last dental visit: ______________ Last professional dental cleaning: ______________

Do you have a history of cavities? ❑ Yes ❑ No

Have you ever had orthodontics? ❑ Yes ❑ No

Have you ever had a jaw joint pain or popping or clicking? ❑ Yes ❑ No

What are your current dental concerns? ______________________

Are you interested in whitening your teeth? ❑ Yes ❑ No

Do you have any interest in improving your smile? ❑ Yes ❑ No

To the best of my knowledge, the information I have given today is true and correct. I understand that this information will be held in confidence and it is my responsibility to inform this office of any future changes in my medical status. Should further information be needed, you have my permission to consult with other health care providers or agencies, who may release such information or x-rays to you. Additionally, I authorize you to release any of my records and/or x-rays and correspond with other health care providers or agencies as you deem necessary during the course of my care. I also give you permission to take clinical photographs as needed.

______________________ ______________________ ______________

Signature of Patient, Parent or Guardian **Please Print Name** **Date**