Scott Anderson DDS

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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: _____

If Patient is a Minor, Give Responsible Party's Name: _____ Relationship to Patient: _____

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: _____

Medical Information:

Physician's Name:_____ City or Clinic: _____

Is your child in good health? ❑ Yes ❑ No Last Physical or Checkup: _____

Does your child have, or has your child had, any of the following? (Please circle all that apply)

Asthma	Rheumatic Fever
Kidney Disease	Fainting spells or dizziness
Heart Disease	Cancer
Diabetes	Heart Valve Concerns
Anemia	

Does your child have any illnesses currently? ❑ Yes ❑ No (If yes, please explain) _____

_____

Does your child have any allergies? ❑ Yes ❑ No _____

Has your child been hospitalized in the last two years? ❑ Yes ❑ No _____

Does your child have artificial joints or heart valves? ❑ Yes ❑ No _____

Is your child taking any medications? If yes, please list _____

_____

Does your child have a history of bleeding excessively after being cut or injured? ❑ Yes ❑ No

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

Dental Information:

Last dental visit:_____ Last professional dental cleaning: _____

Does your child have a history of frequent cavities? ❑ Yes ❑ No

Do you or other family members have a history of gum disease? ❑ Yes ❑ No

Has your child had cavities in the past? ❑ Yes ❑ No

Has your child received a local anesthetic during previous dental visits? ❑ Yes ❑ No

Has your child had unfavorable dental experiences in the past? ❑ Yes ❑ No

Has your child ever seen an orthodontist? ❑ Yes ❑ No

Has your child had any trauma causing injury to teeth or jaws? ❑ Yes ❑ No

Does your child routinely brush at least two times daily? ❑ Yes ❑ No

Do you have concerns about your child's dental health? ❑ Yes ❑ No_____

_____ _____

Parent's signature **Date**

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**