

**PATIENT INFORMATION**

**J. WESLEY ANDERSON, JR. D.D.S.**

First Name \_\_\_\_\_ MI \_\_\_\_\_ Last Name \_\_\_\_\_ Date \_\_\_\_\_  
 Address \_\_\_\_\_ Apt# \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Home# \_\_\_\_\_ Cell# \_\_\_\_\_ Email \_\_\_\_\_  
 Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_ Social Security \_\_\_\_\_ Marital Status \_\_\_\_\_  
 Employer Name \_\_\_\_\_ Employer Phone# \_\_\_\_\_  
**Student Status:** Full Time \_\_\_\_\_ Part Time \_\_\_\_\_ School Name \_\_\_\_\_  
**In Case of Emergency Contact:**  
 Name \_\_\_\_\_ Phone# \_\_\_\_\_  
**Whom may we thank for referring you?** \_\_\_\_\_

**Responsible Party Information**

(If different than patient or under 18)

First Name \_\_\_\_\_ MI \_\_\_\_\_ Last Name \_\_\_\_\_  
 Address \_\_\_\_\_ Apt# \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Home# \_\_\_\_\_ Cell# \_\_\_\_\_ Work# \_\_\_\_\_  
 Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_ Social Security# \_\_\_\_\_  
 Employer Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

**Dental Insurance**

**Primary Insurance Company** \_\_\_\_\_ Phone# \_\_\_\_\_  
 Subscriber's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 First Name \_\_\_\_\_ Last Name \_\_\_\_\_  
 Address \_\_\_\_\_ Apt# \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Home# \_\_\_\_\_ Cell# \_\_\_\_\_ Work# \_\_\_\_\_  
 Member ID # \_\_\_\_\_ Group# \_\_\_\_\_  
 Employer Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

**Secondary Insurance Company** \_\_\_\_\_ Phone# \_\_\_\_\_  
 Subscriber's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 First Name \_\_\_\_\_ Last Name \_\_\_\_\_  
 Address \_\_\_\_\_ Apt# \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Home# \_\_\_\_\_ Cell# \_\_\_\_\_ Work# \_\_\_\_\_  
 Member ID # \_\_\_\_\_ Group# \_\_\_\_\_  
 Employer Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

I certify that I, and/or my dependent(s), have insurance coverage, and assign directly to Dr. Anderson all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. Dr. Anderson may use my health care information and may disclose such information to my insurance company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

\_\_\_\_\_  
Signature of Patient, Parent, Guardian or Personal Representative \_\_\_\_\_ Date \_\_\_\_\_

\_\_\_\_\_  
Please print name of Patient, Parent, Guardian or Personal Representative \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

## Patient Dental History

Reason for today's visit? \_\_\_\_\_

Former Dentist \_\_\_\_\_ City/State \_\_\_\_\_

Date of Last Dental Visit \_\_\_\_\_ Date of Last Dental X-rays \_\_\_\_\_

**Place a mark on the "yes" or "no" to indicate if you have had any of the following:**

Bad Breath	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaw Pain or tiredness	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding Gums	<input type="checkbox"/> Yes <input type="checkbox"/> No	Lip or cheek biting	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blisters on lips or mouth	<input type="checkbox"/> Yes <input type="checkbox"/> No	Loose teeth or broken fillings	<input type="checkbox"/> Yes <input type="checkbox"/> No
Burning sensation on tongue	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mouth Breathing	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chew on one side of the mouth	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mouth pain, brushing	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cigarette, pipe or cigar smoking	<input type="checkbox"/> Yes <input type="checkbox"/> No	Orthodontic treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No
Clicking or popping jaw	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pain around ear	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dry Mouth	<input type="checkbox"/> Yes <input type="checkbox"/> No	Periodontal treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No
Fingernail biting	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to cold	<input type="checkbox"/> Yes <input type="checkbox"/> No
Food collection between the teeth	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to heat	<input type="checkbox"/> Yes <input type="checkbox"/> No
Foreign objects	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to sweets	<input type="checkbox"/> Yes <input type="checkbox"/> No
Grinding teeth	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity when biting	<input type="checkbox"/> Yes <input type="checkbox"/> No
Gums swollen or tender	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sores or growths in your mouth	<input type="checkbox"/> Yes <input type="checkbox"/> No
How often do you floss? _____		How often do you brush? _____	

## Patient Health History

Medical Doctor \_\_\_\_\_ Phone# \_\_\_\_\_

Have you ever used a bisphosphonate medication? Common brand names are Fosamax, Actonel, Atelvia, Didronel, Boniva. Yes No Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine).

**Place a mark on the "yes" or "no" to indicate if you have had any of the following:**

AIDS/HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No	Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Radiation Treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Respiratory Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis/Rheumatism	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fainting or dizziness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Heart Valves	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Scarlet Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Joints	<input type="checkbox"/> Yes <input type="checkbox"/> No	Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shortness of Breath	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sinus Trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No
Back Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Skin Rash	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding abnormally, with extractions or surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis Type	<input type="checkbox"/> Yes <input type="checkbox"/> No	Special Diet	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swollen Feet or Ankles	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemical Dependency	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaundice	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swollen Neck Glands	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemotherapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaw Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Circulatory Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tonsillitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Congenital Heart Lesions	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cortisone Treatments	<input type="checkbox"/> Yes <input type="checkbox"/> No	Low Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tumor or growth on head or neck	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cough, persistent or bloody	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mitral Valve Prolapse	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcer	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Nervous Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Venereal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you wear contact lenses?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	Weight Loss, unexplained	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Psychiatric Care	<input type="checkbox"/> Yes <input type="checkbox"/> No		

**Women:**

Are you pregnant?  Yes  No Due Date: \_\_\_\_\_ Are you nursing?  Yes  No Taking birth control pills?  Yes  No

**Allergies (check all that apply)**

Aspirin	Local Anesthetic
Barbiturates (Sleeping Pills)	Penicillin
Codeine	Sulfa
Iodine	Other _____
Latex	_____

**Medications (list any medications you are currently taking)**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Pharmacy Name \_\_\_\_\_

Phone# \_\_\_\_\_