HEALTH HISTORY

	Yes	No
Are you under medical treatment now?	☐	☐
Have you ever been hospitalized?	☐	☐
Are you taking any medications?	☐	☐
If yes, List ___________________________		
Do you have any allergies?	☐	☐
If yes, List ___________________________		
Do you use tobacco?	☐	☐
Are you pregnant?	☐	☐

Have you ever been diagnosed as having any of the following conditions?

	Yes	No		Yes	No
Arthritis	☐	☐	Hepatitis	☐	☐
Asthma	☐	☐	High Blood Pressure	☐	☐
Bleeding Problems	☐	☐	HIV or AIDS	☐	☐
Cancer	☐	☐	Joint Replacement	☐	☐
Cleft Lip/Palate	☐	☐	Liver Disease	☐	☐
Diabetes	☐	☐	Radiation Therapy	☐	☐
Epilepsy	☐	☐	Vision/Hearing Issues	☐	☐
Heart Disease/Attacks	☐	☐	Other ______________________________		

DENTAL HISTORY

Dentist____ Date of Last Visit____

How often do you brush per day:	☐1X	☐2X	☐3X	☐4+
Do you floss?	☐Yes	☐No		
Do your gums bleed?	☐Yes	☐No		
Are your teeth sensitive to hot/cold?	☐Yes	☐No		
Any joint issues?	☐Yes	☐No		
Have you had orthodontics before?	☐Yes	☐No		
Any difficulty chewing?	☐Yes	☐No		

Areas of Concern (Circle all that apply):

Crowding | Missing/Extra teeth | Cross-bite | Speech Problems
Crooked Teeth | Overbite | Late Eruption | Jaw Problems

History of the following (Circle all that apply):

Trauma to Teeth/Face | Mouth breathing | Snoring | Tongue Thrust
Grinding/Clenching | Headaches/Earaches | Previous orthodontic treatment

Is there anything we should know about you?

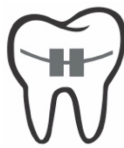
____

____

____

______________________________ ____________ ________________________________

Signature Date Doctor Signature



Anderson Orthodontics

Adult Health History

ABOUT YOU

Name: ______________________________ Birthdate: ____/____/_______ ☐ Male ☐Female

☐Married ☐Single ☐Divorced ☐Widowed SSN: ____

Home Address: _________________________________ Employer: ____________________________________

City: ___________________St: _______ Zip: __________ Occupation: ___________________________________

Phone: ( )___________________ ☐ Home ☐ Cell Employer Address:______________________________

Email: _______________________________________ Work Phone : ( )__________________ Ext: _______

How did you hear about us: _______________________

____

Emergency Contact: _____________________________ Other family members seen by us: ________________

Relation: _______________ Phone: ( )_____________ ____

SPOUSE INFORMATION

Name: ______________________________________ Birthdate: ____/____/_______

Phone: ( )___________________ ☐ Home ☐ Cell Work Phone : ( )__________________ Ext: _______

Employer: ___________________________________ Occupation: _____________________________________

ACCOUNT INFORMATION

Name: ___________________________________ Relation to patient: ____________________

Birthdate:_____/_____/_______ ☐Married ☐Single ☐Divorced ☐Widowed

Phone: ( )___________________ ☐ Home ☐ Cell Work Phone: __________________________

Employer: _________________________________ Occupation:___________________________

DENTAL INSURANCE

Policy Holder: ________________________________ Relation to patient: ___________________________

Policy holder Birthdate: ____/____/______ Policy holder Employer: ________________________

Insurance Company: ___________________________ Insurance Phone: ___________________________

ID# : _______________SSN:___________________ Group #: __________________________________

I hereby authorize payment directly to Dr. Eric Anderson DMD, unless otherwise stated. I understand I am responsible for any charges not covered by my insurance company.

____ _____/_____/__________

Signature Date

CONSENT

I consent to records to be taken as part of the consult process. These may include radiographs and photos. This information is used in our office as part of the treatment process. It can also be used to communicate with other providers or insurance companies.

____ _____/_____/__________

Signature Date