Date: _____ Email: _____

Patient Name: _____ Preferred Name: _____

Social Security #: _____ Age: _____ Date of Birth: _____

Mailing Address: _____ City/State/Zip: _____

Height: _____ Weight: _____ Sex: ☐ Male ☐ Female

Family Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Minor ☐ Other

Home #: _____ Cell #: _____

Work #: _____ Best time to reach you? _____

Employer/School: _____ Occupation: _____

Employer/School Address: _____

***If the person responsible for this patients account is different from the patient, or if patient is a minor, the responsible party MUST fill out the section below:**

Res. Party Name: _____ Relation to Patient: _____

Mailing Address: _____ City/State/Zip: _____

Social Security #: _____ Age: _____ Date of Birth: _____

Family Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Minor ☐ Other

Whom may we thank for referring you? _____

IN CASE OF EMERGENCY, CONTACT: Emergency Contact Name: _____

Emergency Contact Ph #: _____ Relationship: _____

Former Dentist: _____ City/State: _____

Last dental visit: _____ Last dental x-rays: _____

Last physical exam: _____ Physician's name: _____

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

Bad breath	☐ Yes ☐ No	Loose teeth	☐ Yes ☐ No	Trauma	☐ Yes ☐ No
Bleeding gums	☐ Yes ☐ No	Bad taste	☐ Yes ☐ No	TMJ/TMD	☐ Yes ☐ No
Blisters on lips or mouth	☐ Yes ☐ No	Swelling	☐ Yes ☐ No	Dry Mouth	☐ Yes ☐ No
Clicking or jaw popping	☐ Yes ☐ No	Trouble chewing	☐ Yes ☐ No	Difficult extraction	☐ Yes ☐ No
Dry Mouth	☐ Yes ☐ No			Food collection between teeth	☐ Yes ☐ No
Grinding teeth	☐ Yes ☐ No			Periodontal treatment	☐ Yes ☐ No

Allergies:

☐ Aspirin ☐ Local Anesthetic

☐ Penicillin ☐ Latex

☐ Codeine ☐ Metals

☐ Sulfa ☐ Tetanus

Other: _____

Medications:

_____

_____

_____

_____

_____

Pharmacy: _____

Chest pain ☐ Yes ☐ No

Ulcers ☐ Yes ☐ No

Emphysema ☐ Yes ☐ No

Fainting ☐ Yes ☐ No

Dizzy spells ☐ Yes ☐ No

Eating disorder ☐ Yes ☐ No

Seizures/Epilepsy ☐ Yes ☐ No

*Heart murmur ☐ Yes ☐ No

Asthma ☐ Yes ☐ No

Hay Fever ☐ Yes ☐ No

Use of tobacco ☐ Yes ☐ No

Bruise easily ☐ Yes ☐ No

Jaundice ☐ Yes ☐ No

Heart surgery ☐ Yes ☐ No

Kidney trouble ☐ Yes ☐ No

*Transplants ☐ Yes ☐ No

Tuberculosis ☐ Yes ☐ No

HIV, ARC, AIDS ☐ Yes ☐ No

Sinus trouble ☐ Yes ☐ No

*Artificial joint ☐ Yes ☐ No

Thyroid disease ☐ Yes ☐ No

Anemia ☐ Yes ☐ No

Drug addiction ☐ Yes ☐ No

Cold sores ☐ Yes ☐ No

Radiation therapy ☐ Yes ☐ No

Hives/Skin rash ☐ Yes ☐ No

Angina pectoris ☐ Yes ☐ No

Heart problems ☐ Yes ☐ No

Liver disease ☐ Yes ☐ No

High blood pressure ☐ Yes ☐ No

Sickle cell disease ☐ Yes ☐ No

*Rheumatic fever ☐ Yes ☐ No

Cancer ☐ Yes ☐ No

Type: _____

Traveled out of the country within 6 mo.

☐ Yes ☐ No

Diabetes ☐ Yes ☐ No

Arthritis ☐ Yes ☐ No

Sensitivity to:

☐ Cold

☐ Heat

☐ Sweets

☐ Biting

How often do you brush: _____

How often do you floss: _____

Do you consume pop/energy drinks?

If so how often: _____

Do you take Osteoporosis Medications: _____

*Mitral valve prolapses ☐ Yes ☐ No

Hemophilia ☐ Yes ☐ No

Shortness of breath ☐ Yes ☐ No

Glaucoma ☐ Yes ☐ No

*Steroid treatment ☐ Yes ☐ No

Stroke ☐ Yes ☐ No

*Implants ☐ Yes ☐ No

Alcoholism ☐ Yes ☐ No

*Congenital heart problems ☐ Yes ☐ No

Hep A-infection ☐ Yes ☐ No

Hep B-serum ☐ Yes ☐ No

Hep C ☐ Yes ☐ No

Pacemaker ☐ Yes ☐ No

Wheelchair/Handicap ☐ Yes ☐ No

Currently pregnant ☐ Yes ☐ No

How far along: _____

Nursing ☐ Yes ☐ No

I certify that I have read and understand the information above to the best of my knowledge. The above questions have been answered accurately. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information, including diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for service. I agree to be responsible for payment of all services rendered on my or my dependents behalf.

Acknowledgement of Receipt of Notice of Privacy Practice

I have received a copy of this office's Notice of Privacy Practice.

Dr. Anderson and Dr. Floyd appreciate having you as a patient and they look forward to a long, mutually satisfactory relationship. As part of their responsibility to patients, they promise to always provide the very best and cost-effective dental services. They will also make every attempt to make sure that your appointment will be honored in the most time effective way. Please understand that emergencies happen, that can cause unavoidable delays. If for any reason you are unable to make your appointment, we do require a 24-hour cancellation notice. In addition, the doctors expect their patients to honor responsibilities in exchange for services:

- Please provide your insurance information to front desk upon registration.
- All services will be paid at time of appointment. Co-pays also do at time of service.
- All major restorative work results in lab costs. You are responsible for half the procedure costs prior to the shipping to the lab and the remaining balance due at time of delivery.

I have read and fully understand the contents of this agreement:

Signature: _____ Date: _____

For Government Assisted Patients:

By signing the above agreement, you are agreeing to give us 24-hour notice if you cannot make an appointment. Please bring your current Medicaid card to each appointment. The doctors may terminate the dental relationship if you fail one appointment or cancel with 24 hours.