Welcome to Thomas L Anderson, D.D.S. & Associates

Our goal is to help you reach and maintain maximum oral health.
Please fill out this form completely. The better we communicate, the better we can care for you.

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

Today's Date:____/____/_____ E-Mail:_____

Name:_____
Last First Middle Initial

Nick Name:_____ ☐ Male ☐ Female

DOB: ____/____/_____ Age:_____ SSN:_____-_____-_____

Home Address: _____

_____
City State Zip

Marital Status: S M D W Other:_____

HM#:_____-_____-_____ Cell#:_____-_____-_____

Wk#:_____-_____-_____X_____ DL#:_____

Employer:_____

Employers Address:_____

How long there?_____ Occupation:_____

When & Where is the best times to reach you:_____

Whom may we thank for referring you:_____

Other Family seen by us:_____

Previous/Present Dentist:_____ Last Visit:_____

Person Responsible for Account:_____

Wk#: ____-____-_____X_____ HM#:_____-_____-_____

Billing Address:_____

Relationship:_____ SSN:_____-_____-_____

Employer:_____ DL#:_____

Insurance Coverage

Primary

Dental Coverage: ☐ Yes ☐ No

Insurance Co. Name:_____

Insurance Co. Address:_____

Phone#:_____-_____-_____ Group#:_____

Insured's Name:_____ Relation:_____

Isnured's DOB:____/____/_____ SSN:____-_____-_____

Insured's Employer:_____

Secondary

Dental Coverage: ☐ Yes ☐ No

Insurance Co. Name:_____

Insurance Co. Address:_____

Phone#:_____-_____-_____ Group#:_____

Insured's Name:_____ Relation:_____

Isnured's DOB:____/____/_____ SSN:_____-_____-_____

Insured's Employer:_____

Spouse/Guardian Information

Name:_____

Employer:_____

Wk#: ____-____-_____X____ SSN:_____-_____-_____

DOB:____/____/_____ DL#:_____

Emergency Contact:

Name:_____ Relationship:_____

Wk#: ____-____-_____X_____ HM#:_____-_____-_____

Medical History

Do you have a physician: ☐ Yes ☐ No

Physician's Name:_____

Phone#:_____-_____-_____ Date of last visit:____/____/_____

Medical History Continued

Your Current Physical health is: ☐ Good ☐ Fair ☐ Poor

Are you currently under the care of a physician? ☐ Yes ☐ No
Please explain:_____

Are you taking any prescription/over-the-counter or herbal drugs?

Please list each one:_____

_____

Have you ever taken Phen-Fen (also know as redux or pondimin) ☐ Yes ☐ No
If so when:_____

Women Only

Are you taking birth control? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No How many weeks:_____

Are you nursing? ☐ Yes ☐ No

Have you ever had any of the following diseases or medical problems?

Y N Abnormal Bleeding	Y N Hepatitis
Y N Alcohol/Drug Abuse	Y N Herpes/ Fevers
Y N Anemia	Y N High Blood Pressure
Y N Arthritis	Y N HIV+/AIDS
Y N Artificial Bones / Joints/ Valves	Y N Hospitalized for Any Reason
	Y N Kidney Problems
Y N Asthma	Y N Liver Disease
Y N Blood Transfusion	Y N Low Blood Pressure
Y N Cancer / Chemo	Y N Mitral Valve Prolapse
Y N Colitis	Y N Pacemaker
Y N Congenital Heart Defect	Y N Psychiatric Problems
Y N Diabetes	Y N Radiation Treatment
Y N Difficulty Breathing	Y N Rheumatic / Scarlet Fever
Y N Emphysema	Y N Seizures
Y N Epilepsy	Y N Shingles
Y N Fainting Spells	Y N Sickle Cell Disease / Traits
Y N Frequent Headaches	Y N Sinus Problems
Y N Glaucoma	Y N Stroke
Y N Hay Fever	Y N Thyroid Problems
Y N Heart Attack	Y N Tuberculosis
Y N Heart Murmur	Y N Ulcers
Y N Heart Surgery	Y N Venereal Disease
Y N Hemophilia	

Please List any other medical condtion(s) that you ever had:_____

_____

Are you allergic to any of the following?

Y N Aspirin	Y N Erythromycin	Y N Metals
Y N Codeine	Y N Jewelry	Y N Penicillin
Y N Dental Anesthetics	Y N Latex	Y N Tetracycline

Other Allergies:_____

Dental History

Why have you come to the dentist today?

_____

_____

Do you require antibiotics before dental work? ☐ Yes ☐ No

Are you Currently in pain? ☐ Yes ☐ No

Have you ever had serious/difficult problem associated with dental work? ☐ Yes ☐ No

Do you now or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)? ☐ Yes ☐ No

Your current dental health is: ☐ Good ☐ Fair ☐ Poor

Do you like your smile? ☐ Yes ☐ No

Fresher breath? ☐ Yes ☐ No

Would you like whiter teeth? ☐ Yes ☐ No

How many times a **week** do you floss?____a **day** do you brush?____

Type of toothbrush bristles? ☐ Soft ☐ Medium ☐ Hard

Do you smoke or use tobacco in any other form? ☐ Yes ☐ No

I understand that the information that I have given today is correct to the best of my knowledge. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent. I understand that I will be informed of my insurance estimates, if any, and that I am responsible for my copayments at the time of service. The insurance benefits quoted are not a guarantee of payment, and I am ultimately responsible for any remaining balance on my acct. 24 hour cancellation notice is required or a cancellation fee may be charged. In the event my account becomes delinquent, I understand I will be responsible for all collection fees.

_____ _____
Signature Date

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who ay be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices.

Acknowledgement of Receipt of State of Privacy Practices

I acknowledge that a copy of the Statement of Privacy Practices for Thomas L. Anderson & Associates was made available for me. I have reviewed the Statement of Privacy Practices describing the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Statement of Privacy Practices also describes my rights and responsibilities; and duties of this office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility.

Thomas L. Anderson & Associates reserves that right to change the privacy practices that are described in the Statement of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed to me.

Additional Disclosure Authority

I addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my protected health care information to the persons indicated below:

Any member of my immediate family : ◯YES ◯NO

Spouse only: ◯YES ◯NO

Other(Please Specify Below): ◯YES ◯NO

I authorize that I may be contacted via the ways listed below in regards to my treatment, payment for services, or in the performance of office health care operations:

E-Mail: ◯YES ◯NO

Telephone Messages: ◯YES ◯NO

Text Messages: ◯YES ◯NO

Fax: ◯YES ◯NO

_____ _____

Signature Date

_____ _____

Patient name (Printed) Relationship to Patient