New Patient Dental Questionnaire

NAME _____ DATE_____

How did you hear about our office? _____

Date of last dental cleaning visit_____ Previous dentist_____

Why are you switching dentists? _____

What concerns you most about your mouth?_____

What is important to you when you receive dental care?_____

How often do you brush your teeth? _____ Floss? _____

What do you sip or snack during the day? Ex: (coffee, water, tea, soda, sports drinks, juice, candy, mints)

_____

Do you smoke, vape or use tobacco? _____ How long? _____

Do you have missing teeth?_____How long? _____

Are you happy with the color of your teeth? _____

Are you aware of clenching or grinding? _____ If yes, do you wear a guard?_____

Have you ever had orthodontics (braces)? _____

Have you ever had retainers, partials, dentures or night guard?_____ How long?_____

Did you bring these items with you today? _____

MEDICAL HISTORY Version 04/2023(Copy)

Patient Name: Birth Date: Date Created:

Are you under a physician's care now?	◯ Yes ◯ No	If yes
Have you ever been hospitalized or had a major operation?	◯ Yes ◯ No	If yes
Have you ever had a serious head or neck injury?	◯ Yes ◯ No	If yes
Are you taking any medications, pills, or drugs? Please list.	◯ Yes ◯ No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	◯ Yes ◯ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	◯ Yes ◯ No	If yes
Are you on a special diet?	◯ Yes ◯ No	
Do you use tobacco?	◯ Yes ◯ No	
Do you use marijuana/cannabis?	◯ Yes ◯ No	
If you have diabetes what is your A1C level?		
Do you have a history of blood disorders?	◯ Yes ◯ No	
Have you been diagnosed with Sleep Apnea? If Yes, Do you use a CPAP?	◯ Yes ◯ No	If yes

WOMEN: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic

☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Other? ☐ If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive	◯ Yes ◯ No	Cortisone Medicine	◯ Yes ◯ No	Hemophilia	◯ Yes ◯ No	Radiation Treatments	◯ Yes ◯ No
Alzheimer's Disease	◯ Yes ◯ No	Diabetes	◯ Yes ◯ No	Hepatitis	◯ Yes ◯ No	Recent Weight Loss	◯ Yes ◯ No
Anaphylaxis	◯ Yes ◯ No	Drug Addiction/Alcoholism	◯ Yes ◯ No	Renal Dialysis	◯ Yes ◯ No	Anemia	◯ Yes ◯ No
Easily Winded	◯ Yes ◯ No	Rheumatic Fever	◯ Yes ◯ No	Angina	◯ Yes ◯ No	Emphysema	◯ Yes ◯ No
High Blood Pressure	◯ Yes ◯ No	Rheumatism	◯ Yes ◯ No	Arthritis/Gout	◯ Yes ◯ No	Epilepsy or Seizures	◯ Yes ◯ No
High Cholesterol	◯ Yes ◯ No	Scarlet Fever	◯ Yes ◯ No	Artificial Heart Valve	◯ Yes ◯ No	Excessive Bleeding	◯ Yes ◯ No
Hives or Rash	◯ Yes ◯ No	Shingles	◯ Yes ◯ No	Artificial Joint	◯ Yes ◯ No	Excessive Thirst	◯ Yes ◯ No
Hypoglycemia	◯ Yes ◯ No	Sickle Cell Disease	◯ Yes ◯ No	Asthma	◯ Yes ◯ No	Fainting Spells/Dizziness	◯ Yes ◯ No
Irregular Heartbeat	◯ Yes ◯ No	Sinus Trouble	◯ Yes ◯ No	Blood Disease	◯ Yes ◯ No	Frequent Cough	◯ Yes ◯ No
Kidney Problems	◯ Yes ◯ No	Spina Bifida	◯ Yes ◯ No	Blood Transfusion	◯ Yes ◯ No	Leukemia	◯ Yes ◯ No
Stomach/Intestinal Disease	◯ Yes ◯ No	Breathing Problems	◯ Yes ◯ No	Frequent Headaches	◯ Yes ◯ No	Liver Disease	◯ Yes ◯ No
Stroke	◯ Yes ◯ No	Bruise Easily	◯ Yes ◯ No	Herpes	◯ Yes ◯ No	Low Blood Pressure	◯ Yes ◯ No
Swelling of Limbs	◯ Yes ◯ No	Cancer	◯ Yes ◯ No	Glaucoma	◯ Yes ◯ No	Lung Disease	◯ Yes ◯ No
Thyroid Disease	◯ Yes ◯ No	Chemotherapy	◯ Yes ◯ No	Hay Fever	◯ Yes ◯ No	Mitral Valve Prolapse	◯ Yes ◯ No
Chest Pains	◯ Yes ◯ No	Heart Attack/Failure	◯ Yes ◯ No	Osteoporosis	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No
Cold Sores/Fever Blisters	◯ Yes ◯ No	Heart Murmur	◯ Yes ◯ No	Pain in Jaw Joints	◯ Yes ◯ No	Tumors or Growths	◯ Yes ◯ No
Congenital Heart Disorder	◯ Yes ◯ No	Heart Pacemaker	◯ Yes ◯ No	Parathyroid Disease	◯ Yes ◯ No	Ulcers	◯ Yes ◯ No
Heart Trouble/Disease	◯ Yes ◯ No	Depression/Anxiety	◯ Yes ◯ No	Venereal Disease	◯ Yes ◯ No	Yellow Jaundice	◯ Yes ◯ No
Periodontal Disease	◯ Yes ◯ No						

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes

Artificial Joints:

Have you had a joint replacement? If yes, date replaced and joint. ◯ Yes ◯ No If yes

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X Date:_____

Patient Registration

Patient's name _____ Date of Birth_____

Social Security Number _____ (Account Guarantor)

Sex: Male/Female If minor, name of legal guardian_____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email address: _____

Mailing address: _____ City_____ State____ ZIP_____

Employer_____

Spouse/Parent Name _____ Employer_____ DOB_____

Whom may we thank for referring you to our office? _____

INSURANCE INFORMATION: ☐ Not Covered by Dental Insurance ☐ In-Office Membership Plan

PRIMARY DENTAL INSURANCE

Subscriber: ☐ Self ☐ Spouse ☐ Parent Name_____ DOB_____

Subscriber SS# _____ or Member/Subscriber ID # _____

Dental Insurance Co._____ Group#_____ Ph#_____

Claims Address: _____

SECONDARY DENTAL INSURANCE

Subscriber: ☐ Self ☐ Spouse ☐ Parent Name_____ DOB_____

Subscriber SS# _____ or Member/Subscriber ID # _____

Dental Insurance Co._____ Group#_____ Ph#_____

Claims Address: _____

MEDICAL INSURANCE

Subscriber: ☐ Self ☐ Spouse ☐ Parent Name_____ DOB_____

Medical Insurance Co. _____ Subscriber ID#_____ Group#_____

Claims Address: _____

PRIVACY and CONSENT DISCLOSURE

I authorize Deanna J. Anderson, DDS and associates at Anderson General Dentistry & Implants to perform diagnostic procedures, such as, x-rays, study models, photographs or any other form of diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the patient's dental needs. I authorize the dental staff to perform any dental service as may be necessary for proper dental care with my informed consent.

I authorize and consent to the disclosure of my protected health information to carry out treatment, payment activities and health care operations.

I understand that I may withdraw or revoke this consent in writing. Any revocation would not pertain to information already used or disclosed prior receipt of written withdrawal.

ACKNOWLEDEMENT OF RECEIPT OF PRIVACY PRACTICES NOTICE

I, _____, acknowledge that I have been offered a copy of the Notice of Privacy Practices (available upon request) from the above named practice.

OFFICE and FINANCIAL POLICY

BROKEN APPOINTMENTS: ***Should a cancellation occur with less than 48 hours notice not including weekends we reserve the right to apply a $50 broken appointment fee.*** Excessive broken appointments without appropriate notice will result in pre-payment with credit card to secure an appointment or dismissal from the practice. Please help us serve you and our other patients by keeping your scheduled appointment or providing sufficient notice.

INSURANCE: Please remember your insurance policy is a contract between you, your employer and your insurance company. Our relationship is with you and not your insurance company. ***Please understand we will provide an estimate to you, however, it is not a guarantee that your insurance will pay exactly as estimated.*** Upon request, we can submit a pre-determination request to your insurance plan, this is an estimate provided by your insurance company and not a guarantee of payment. Anderson General Dentistry & Implants is not responsible for denials or alternative allowances your plan may determine after services are rendered. ***Any balance is your responsibility whether or not your insurance company pays any portion.***

PAYMENT IS DUE AT TIME OF SERVICE: FULL PAYMENT is due at time of service. If insurance benefits apply, **ESTIMATED PATIENT CO-PAYMENTS and DEDUCTIBLES are due at the time of service.**

We accept payments in the form of Cash, Check, Visa, Mastercard, Discover, American Express and Care Credit. We offer some no interest options with Care Credit, apply at www.carecredit.com . We also work with Proceed Finance as another financing option.

MINORS ACCOMPANIED BY AN ADULT: Payment or co-payment is expected from the parent accompanying the child to the appointment. Parents/Guardians are expected to remain in the reception area during treatment and will not be permitted in the treatment rooms. This allows us to focus on your child and their dental needs.

I confirm that I have read, understand and agree to all of the above terms and conditions of Anderson General Dentistry & Implants. I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me.

Signature_____ (patient or guardian) Date_____