Eric P. Andersen, DDS
Family & Cosmetic Dentistry
400 North Allen Drive #101
Allen, Texas 75013
(972) 727-4415

PATIENT INFORMATION

Date: _____

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

Email: _____ Drivers License # _____

PERSONAL INFORMATION

Name: _____

Address: _____

City: _____ Zip: _____

Birthdate: _____ Age: _____

Employer: _____

City: _____ Zip: _____

Position: _____

Social Security #: _____

SPOUSE/PARENT INFORMATION

Name: _____

Employer: _____

City: _____ Zip: _____

Birthdate: _____ Age: _____

Business Phone: _____

Cell Phone: _____

Position: _____

Social Security #: _____

***Whom may we thank for referring you/how did you hear about us?* _____**

Person to contact in case of emergency: _____ Relationship: _____

Their Home Phone: _____ Their Cell Phone: _____

DENTAL INSURANCE INFORMATION

Name of Insured: _____

Insurance Carrier Name: _____

Insurance Address: _____

_____

Social Security/ID#: _____

Employer: _____

Group #: _____

Insurance Phone: _____

Do you have, or have you ever had any of the following:

- ☐ AIDS/HIV Positive
- ☐ Alzheimer's Disease
- ☐ Anaphylaxis
- ☐ Anemia
- ☐ Angina
- ☐ Arthritis/Gout
- ☐ Artificial Heart Valve
- ☐ Artificial Joint(s)
- ☐ Asthma
- ☐ Blood Disease
- ☐ Blood Transfusion
- ☐ Breathing Problem
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Chest Pains
- ☐ Cold Sores/Fever Blisters
- ☐ Congenital Heart Disorder
- ☐ Convulsions
- ☐ Cortisone Medicine
- ☐ Diabetes
- ☐ Drug Addiction
- ☐ Easily Winded
- ☐ Emphysema
- ☐ Epilepsy or Seizures
- ☐ Excessive Bleeding
- ☐ Excessive Thirst
- ☐ Fainting Spells/Dizziness
- ☐ Frequent Cough
- ☐ Frequent Diarrhea
- ☐ Frequent Headaches
- ☐ Genital Herpes
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Heart Attack/Failure
- ☐ Heart Murmur
- ☐ Heart Pacemaker
- ☐ Heart Trouble/Disease
- ☐ Hemophilia
- ☐ Hepatitis A, B, C
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ Hives or Rash
- ☐ Hypoglycemia
- ☐ Irregular Heartbeat
- ☐ Kidney Problems
- ☐ Leukemia
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Lung Disease
- ☐ Mitral Valve Prolapse
- ☐ Pain in Jaw Joints
- ☐ Parathyroid Disease
- ☐ Psychiatric Care
- ☐ Radiation Treatments
- ☐ Recent Weight Loss
- ☐ Renal Dialysis
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Scarlet Fever
- ☐ Shingles
- ☐ Sickle Cell Disease
- ☐ Sinus Trouble
- ☐ Spina Bifida
- ☐ Stomach/Intestinal Disease
- ☐ Stroke
- ☐ Swelling of Limbs
- ☐ Thyroid Disease
- ☐ Tonsilitis
- ☐ Tuberculosis
- ☐ Tumors or Growths
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Yellow Jaundice

1. Are you in good health? ☐ Yes ☐ No

2. Date of last medical exam? _____

3. Have you been hospitalized? ☐ Yes ☐ No
If so, details/date(s): _____

4. Are you taking any medications? ☐ Yes ☐ No
If so, list: _____
_____
_____

5. Do you have a disease/transplant that has depressed your immune system? ☐ Yes _____ ☐ No

6. Have you taken Fen-Phen? ☐ Yes _____ ☐ No

7. Are you sensitive/allergic to any medications? ☐ No
☐ Yes: _____
_____

8. Do you have any disease or condition you think we should know about? ☐ No ☐ Yes: _____
_____
_____

9. Do you use tobacco? ☐ Yes-type: _____ ☐ No

10. Do you wear a cardiac pacemaker? ☐ Yes ☐ No

11. Have you had heart surgery? ☐ Yes-date: _____ ☐ No

12. Are you now under the care of a MD? ☐ Yes ☐ No

13. Have you had any serious illnesses? ☐ Yes ☐ No

14. Are you sensitive to latex or bananas? ☐ Yes ☐ No

15. Do you have a history of chemical dependency? ☐ No
☐ Yes: _____

16. Do you need to be premedicated prior to dental treatment? ☐ Yes medication: _____ ☐ No

Physician's Name: _____

Address: _____

Phone: _____

WOMEN ONLY

Are you taking birth control medication? ☐ No ☐ Yes: _____
Are you now pregnant? ☐ No ☐ Yes-how long? ☐ 1-3 mos. ☐ 3-6 mos. ☐ 6-9 mos.
Physician's Name: _____ **Phone:** _____

DENTAL HISTORY

1. **How long since your last dental visit?** _____
2. **Reason for this visit?** _____
   _____
3. **Are you having any discomfort or problems with your teeth or gums?** _____
4. **Have you ever been treated for periodontal (gum) disease?** ☐ Yes ☐ No **If so, by whom?**
   _____
5. **Do you have dental implants?** ☐ Yes ☐ No **If so, who placed them and when were they placed?**

6. **Have you ever whitened your teeth? If so, do you have trays? _____**

7. **Have you had orthodontic treatment? □ Yes □ No If yes, do you wear retainers? _____**

8. **Do you notice any mouth odor? □ Yes □ No**
9. **Have you ever had Orthognathic/Oral Surgery? □ Yes □ No _____**

10. **Have you been diagnosed with Sleep Apnea? □ Yes □ No If yes, do you use a C-PAP machine or mouth appliance? _____**

11. **Have you ever been treated for a TMJ disorder? □ Yes □ No _____ If yes, do you wear a night guard? □Yes □No**
12. **Do you snore? □ Yes □ No _____**

13. **Do you have a history of hypertension? □ Yes □ No**

14. **Have you ever had a sleep study? □ Yes □ No**

15. **Are you prone to frequent headaches? □Yes □ No _____**
16. **Do you have sores, blisters or swelling on your gums, lips or cheeks? □ Yes □ No _____**
17. **Have you ever had an allergic reaction to a metal filling, crown or dental appliance? □ Yes □ No _____**
18. **Do your gums bleed when you brush? □ Yes □ No _____**

19. **How often do you floss? _____**
20. **Are you aware of clenching or grinding your teeth? □ Yes □ No _____**
21. **Have you ever used an electric toothbrush? □ Yes □ No _____**
22. **When did you last have an oral cancer screening exam? _____**
23. **Have you ever been told you gasp or stop breathing during sleep? □ Yes □ No _____**
24. **Are you excessively tired during the day? □ Yes □ No _____**

Previous Dentist: _____City: _____Phone: _____

IS THERE ANY ADDITIONAL MEDICAL OR DENTAL INFORMATION WE MAY NEED TO KNOW ABOUT BEFORE BEGINNING TREATMENT?

_____

_____

_____

CONSENT

Adult: I hereby consent to the treatment indicated on my treatment form including the use of any anesthetics, sedatives or x-rays as may be deemed necessary by Eric Andersen, DDS.

Minor: I, being the parent or guardian of the above named minor patient, do hereby authorize the performance of dental services upon this patient and whatever procedures the judgment of Eric Andersen, DDS may dictate in order to carry out treatment procedures as outlined on the treatment plan. I also authorize and request the administration of such anesthetics and/or sedatives as may be deemed advisable by Eric Andersen, DDS.

I understand I am financially responsible for payment in full of all charges. I understand that my insurance policy is a contract between my insurance carrier and me and I agree to be responsible for payment of services not paid, in whole or in part, by my dental insurance carrier.

I attest to the accuracy of the information I have provided in this form.

_____ _____

Patient Signature Date Parent/Guardian Signature Date

Notes: _____