



Anderson Orthodontics, PC  
Kimsey K. Anderson, DDS, MS

WELCOME TO OUR OFFICE

Date \_\_\_\_\_

Name \_\_\_\_\_  Male  Female

First M.I. Last

Nickname (optional) \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Mr. Mrs. Ms. Miss Dr.

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone # \_\_\_\_\_ Daytime Phone # to confirm appts. \_\_\_\_\_ Ask for \_\_\_\_\_

Email (Strictly Confidential) \_\_\_\_\_

Special Interests / Hobbies \_\_\_\_\_

Employer's Name \_\_\_\_\_ Phone # \_\_\_\_\_ Occupation \_\_\_\_\_

Position \_\_\_\_\_ Length of Employment \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

**PRIMARY ORTHODONTIC INSURANCE COVERAGE**

Name of Insurance Company \_\_\_\_\_ Phone # \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Social Security # (for Ins.) \_\_\_\_\_ Local # \_\_\_\_\_

Group # \_\_\_\_\_ Policy and/or ID # \_\_\_\_\_

**Secondary Orthodontic Insurance Coverage  Yes  No**

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone # \_\_\_\_\_

First M.I. Last

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Social Security # (for Ins.) \_\_\_\_\_ Birth Date \_\_\_\_\_ Occupation \_\_\_\_\_

Employer's Name \_\_\_\_\_ Phone # \_\_\_\_\_

Position \_\_\_\_\_ Length of Employment \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Name of Insurance Company \_\_\_\_\_ Phone # \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Local # \_\_\_\_\_ Group # \_\_\_\_\_ Policy and/or ID # \_\_\_\_\_

Name of Spouse \_\_\_\_\_

Whom may we thank for referring you? (Dentist &/or Friend) \_\_\_\_\_

Names & ages of children \_\_\_\_\_

**MEDICAL HISTORY**

Physician's Name \_\_\_\_\_ Last Medical Exam \_\_\_\_\_

Address \_\_\_\_\_ Phone # \_\_\_\_\_

If currently under the care of a physician, for what reason? \_\_\_\_\_

If taking any medications now, what? \_\_\_\_\_ For what purpose? \_\_\_\_\_

Are you taking Osteoporosis medication? If so, what type? \_\_\_\_\_

Have you ever had any serious illness or operations? \_\_\_\_\_

Are you allergic to:  Penicillin  Codeine  Latex  Metals  Local Anesthetic Injections  
 Other \_\_\_\_\_

Women: If pregnant, when is your due date? \_\_\_\_\_

**DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? (PLEASE indicate Yes or No for each item)**

- |  |  |  |  |
|--|--|--|--|
| Yes No   | Yes No   | Yes No   | Yes No   |
| <input type="checkbox"/> <input type="checkbox"/> Heart Disease            | <input type="checkbox"/> <input type="checkbox"/> Tuberculosis or Lung Disease | <input type="checkbox"/> <input type="checkbox"/> Frequent Headaches                 | <input type="checkbox"/> <input type="checkbox"/> Anemia                     |
| <input type="checkbox"/> <input type="checkbox"/> Abnormal Blood Pressure  | <input type="checkbox"/> <input type="checkbox"/> Diabetes                     | <input type="checkbox"/> <input type="checkbox"/> Cancer or Leukemia                 | <input type="checkbox"/> <input type="checkbox"/> Pacemaker                  |
| <input type="checkbox"/> <input type="checkbox"/> Rheumatic Fever          | <input type="checkbox"/> <input type="checkbox"/> Epilepsy                     | <input type="checkbox"/> <input type="checkbox"/> Radiation/Chemo Therapy            | <input type="checkbox"/> <input type="checkbox"/> Prolonged Bleeding         |
| <input type="checkbox"/> <input type="checkbox"/> Congenital Heart Lesions | <input type="checkbox"/> <input type="checkbox"/> Venereal Disease             | <input type="checkbox"/> <input type="checkbox"/> Asthma or Other Breathing Problems | <input type="checkbox"/> <input type="checkbox"/> Herpes                     |
| <input type="checkbox"/> <input type="checkbox"/> Heart Murmur             | <input type="checkbox"/> <input type="checkbox"/> Hepatitis or Liver Problems  | <input type="checkbox"/> <input type="checkbox"/> Glaucoma                           | <input type="checkbox"/> <input type="checkbox"/> Arthritis                  |
| <input type="checkbox"/> <input type="checkbox"/> Stroke                   | <input type="checkbox"/> <input type="checkbox"/> Jaundice                     | <input type="checkbox"/> <input type="checkbox"/> Immune Disorder                    | <input type="checkbox"/> <input type="checkbox"/> Sinus Trouble or Hay Fever |
| <input type="checkbox"/> <input type="checkbox"/> Ulcers                   | <input type="checkbox"/> <input type="checkbox"/> Nervous Disorder             | <input type="checkbox"/> <input type="checkbox"/> Growth Disorder                    | <input type="checkbox"/> <input type="checkbox"/> Allergy to Medication      |
|  |  |  | <input type="checkbox"/> <input type="checkbox"/> MERSA                      |

If yes, explain \_\_\_\_\_

**DENTAL HISTORY**

General Dentist \_\_\_\_\_ Date of last cleaning and check up? \_\_\_\_\_

Are you having any dental pain at this time? \_\_\_\_\_

**PLEASE CHECK BOX IF YOU HAVE HAD OR NOTICE ANY OF THE FOLLOWING**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Teeth Sensitive to Hot, Cold, Sweets or Pressure  | <b>Oral Habits</b>  | <input type="checkbox"/> Pain and/or Swelling of Gums   |
| <input type="checkbox"/> Traumatic Injury to Teeth or Mouth  | <input type="checkbox"/> Smoking/Tobacco use  | <input type="checkbox"/> Bleeding of Gums when Brushing |
| <input type="checkbox"/> Emergency Treatment required  | <input type="checkbox"/> Thumb Sucking <input type="checkbox"/> Fingernail or <input type="checkbox"/> Cheek Biting | <input type="checkbox"/> Mouth Breathing                |
| <input type="checkbox"/> Pain or Tenderness around Ear, Joint or Side of Face  | <input type="checkbox"/> Clenching or Grinding of Teeth <input type="checkbox"/> Day <input type="checkbox"/> Night | <input type="checkbox"/> Tonsils or Adenoids Removed    |
| <input type="checkbox"/> Difficulty in: <input type="checkbox"/> Opening <input type="checkbox"/> Closing <input type="checkbox"/> Chewing | <input type="checkbox"/> Periodontal Treatment (Gum)  | <input type="checkbox"/> Missing Teeth                  |
| <input type="checkbox"/> Clicking or Popping of Jaw Joint  | <input type="checkbox"/> Loosening of your Teeth  | <input type="checkbox"/> Additional Teeth               |
| <input type="checkbox"/> TMJ Treatment   | <input type="checkbox"/> Extractions  |   |

If yes, explain \_\_\_\_\_

**ORTHODONTIC HISTORY**

Please explain your chief concern with your teeth or bite? \_\_\_\_\_

Have you had prior orthodontic treatment?  Yes  No When? \_\_\_\_\_

Have you had other orthodontic consultations?  Yes  No When? \_\_\_\_\_

Has any member of your family had orthodontic treatment?  Yes  No When? \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_ Reviewed \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_ Reviewed \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_ Reviewed \_\_\_\_\_