# 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 __________

Address ______________________ City ______________ State ______ Zip Code ________

Phone # __________ Daytime Phone # to confirm appts. ______________ Ask for ____________

Mother's Name ____________ Address ______________ Cell Ph. __________ Work Ph. __________

Father's Name ____________ Address ______________ Cell Ph. __________ Work Ph. __________

School ______________________ Email (Strictly Confidential) ______________________

Names & ages of siblings ________________________________________

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

## PRIMARY PERSON RESPONSIBLE FOR ACCOUNT

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 ________

Is primary person covered under an orthodontic insurance plan? ❑ Yes ❑ No

If yes, Name of Insurance ______________________________ Phone # ____________

Address ______________________ City ______________ State ______ Zip Code ________

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 ______________________________ Phone # ____________

Address ______________________ City ______________ State ______ Zip Code ________

Local # ______________ Group # ______________ Policy and/or ID # ______________

PLEASE COMPLETE MEDICAL HISTORY ON BACK → OVER

## 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? ____________

Have you ever had any serious illness or operations? ______________________

Are you allergic to: ❑ Penicillin ❑ Codeine ❑ Latex ❑ Metals ❑ Local Anesthetic Injections

❑ Other ______________________

**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 | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| ❑ | ❑ | Heart Disease | ❑ | ❑ | Tuberculosis or Lung Disease | ❑ | ❑ | Frequent Headaches | ❑ | ❑ | Anemia |
| ❑ | ❑ | Abnormal Blood Pressure | ❑ | ❑ | Diabetes | ❑ | ❑ | Cancer or Leukemia | ❑ | ❑ | Pacemaker |
| ❑ | ❑ | Rheumatic Fever | ❑ | ❑ | Epilepsy | ❑ | ❑ | Radiation/Chemo Therapy | ❑ | ❑ | Prolonged Bleeding |
| ❑ | ❑ | Congenital Heart Lesions | ❑ | ❑ | Venereal Disease | ❑ | ❑ | Asthma or Other Breathing Problems | ❑ | ❑ | Herpes |
| ❑ | ❑ | Heart Murmur | ❑ | ❑ | Hepatitis or Liver Problems | ❑ | ❑ | Glaucoma | ❑ | ❑ | Arthritis |
| ❑ | ❑ | Stroke | ❑ | ❑ | Jaundice | ❑ | ❑ | Immune Disorder | ❑ | ❑ | Sinus Trouble or Hay Fever |
| ❑ | ❑ | Ulcers | ❑ | ❑ | Nervous Disorder | ❑ | ❑ | Growth Disorder | ❑ | ❑ | Allergy to Medication |
| | | | | | | | | | ❑ | ❑ | 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**

- ❑ Teeth Sensitive to Hot, Cold, Sweets or Pressure
- ❑ Traumatic Injury to Teeth or Mouth
- ❑ Emergency Treatment required
- ❑ Pain or Tenderness around Ear, Joint or Side of Face
- ❑ Difficulty in: ❑ Opening ❑ Closing ❑ Chewing
- ❑ Clicking or Popping of Jaw Joint
- ❑ TMJ Treatment

**Oral Habits**

- ❑ Smoking/Tobacco use
- ❑ Thumb Sucking ❑ Fingernail or ❑ Cheek Biting
- ❑ Clenching or Grinding of Teeth ❑ Day ❑ Night
- ❑ Periodontal Treatment (Gum)
- ❑ Loosening of your Teeth
- ❑ Extractions

- ❑ Pain and/or Swelling of Gums
- ❑ Bleeding of Gums when Brushing
- ❑ Mouth Breathing
- ❑ Tonsils or Adenoids Removed
- ❑ Missing Teeth
- ❑ Additional Teeth

If yes, explain ______________________

## ORTHODONTIC HISTORY

Please explain your chief concern with your child's teeth? ______________________

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? ____________

Please answer the following questions:

Father's Height ________ Mother's Height ________ The patient's teeth most resemble? ❑ Mother ❑ Father

FEMALE PATIENTS ONLY: Has patient started a menstrual cycle? ❑ Yes ❑ No When? ____________

*Signature ______________________ Date ____________ Reviewed ____________

*Signature ______________________ Date ____________ Reviewed ____________

*Signature ______________________ Date ____________ Reviewed ____________

*Must be signed by custodial parent or guardian