ABOUT YOU (THE PATIENT): **Today's Date: _____**

Name: _____ I prefer to be called: _____
Birthdate: _____ Age: _____ Social Security #: _____
Home Address: _____
City/State: _____ Zip: _____
Home #: _____ Work #: _____ Cell #: _____
Occupation: _____ Employer: _____ Address: _____
Spouse Name: _____ Birthdate: _____ Social Security #: _____
Employer: _____ Work #: _____ Cell #: _____

Referred By: _____

Person Responsible for Account: _____
Billing Address: _____ City/State: _____ Zip: _____
Employer: _____ Work #: _____ Cell #: _____
Relationship to you: _____ Social Security #: _____

Dental Insurance: _____
Primary Insurance Company Name: _____ Group #: _____
Secondary Insurance Company Name: _____ Group #: _____
In case of an emergency, please contact: _____ Phone #: _____

MEDICAL HISTORY:
Physician: _____ Phone #: _____
Your current health is: Good_____ Fair_____ Poor_____
Are you currently under the care of a physician? No _____ Yes _____
If yes, please explain: _____
Do you have any existing illness? No_____ Yes_____
If yes, please explain: _____
Have you been hospitalized in the past two years? No_____ Yes_____
If yes, please explain: _____
******DO YOU BLEED EXCESSIVELY WHEN CUT? _____YES_____NO**
Do you use tobacco products? No____ Yes _____ If yes, what?_____
Are you taking any medications, pills or drugs? No_____ Yes _____ If yes, please list:
_____

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

Y	N	High Blood Pressure	Y	N	Liver Disease
Y	N	Blood Disease	Y	N	Kidney Disease
Y	N	Rheumatic Fever	Y	N	Hepatitis
Y	N	Heart Murmur/Mitral Valve Prolapse	Y	N	Asthma
Y	N	Diabetes	Y	N	Tuberculosis
Y	N	Stroke	Y	N	Epilepsy
Y	N	Arthritis/ Rheumatoid Arthritis	Y	N	Tumor History
Y	N	Radiation/ Chemo Therapy	Y	N	Heart Disease
Y	N	Cancer_____	Y	N	Are You Pregnant?
Y	N	Acid Reflux/GERD	Y	N	Hearing Problems
Y	N	Pacemaker/ Artificial Heart Valve	Y	N	Joint Replacement
Y	N	Systemic Pulmonary Shunt	Y	N	HIV/ AIDS/ VD
Y	N	Hyper/ Hypo Thyroid	Other:_____		

ALLERGY TO: Penicillin Y or N Other Antibiotics Y or N Other Y or N

Have you ever been treated for osteoporosis or cancer with *bisphosphonates*????? Y N

Have you ever taken any of the following medications?:

Actonel (risedronate)	**Aredia (pamidronate)**	**Bonefos (clodronate)**
Boniva (ibandronate)	**Didronel (etidronate)**	**Fosamax (alendronate)**
Ostac (clodronate)	**Skelid (tiludronate)**	**Zometa (zoledronic acid)**

DENTAL HISTORY:

Do you have any present dental complaints? If yes, please explain: _____
_____
When was your last full mouth X-ray taken? _____
When was your last cleaning? _____ Where? _____
Have you ever been instructed in the prevention of decay and gum disease?_____

REMARKS:

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. **I authorize the dental staff to perform any necessary dental services with my informed consent that I may need during diagnosis and treatment.**

Signature: _____ Date: _____

Signature of Guardian (if patient is a minor): _____

PAYMENT ARRANGEMENT:

I will be paying by:

- **CASH**
- **CREDIT CARD (Visa, Discover, Master Card, American Express)**
- **INSURANCE** –Insurance assignment with benefits payable to Dr. Joseph R. Anderson and patient's understanding that their portion is due at the time services are rendered. Patient will be responsible for any benefits unpaid by the insurance company.
- **There will be a $75.00 charge to your card on file for any missed appointments or cancellations without a 24 hour notice.**

Signature: _____ Drivers License #: _____ Date: _____

Signature of Legal Guardian (if patient is a minor):

_____

Patient's Name: _____ Date: _____

TMJ (Temporomandibular Joint) Health Questionnaire

(Please circle yes or no below on every question)

The temporomandibular joint is the articulation between the mandible and the two temporal bones of the skull. This joint is most commonly used when opening and closing your mouth. Read over the below questions and let us know if you have suffered from any of these problems?

PAIN SYMPTONS:					
Do you get tension headaches?	Y	N	Do you get headaches in the right or left temple areas?	Y	N
Do you get migraine headaches?	Y	N			
Do you frequently have neck aches or stiff neck muscles?	Y	N	Do you get headaches in the back of your head?	Y	N
Do you have trouble sleeping soundly?	Y	N	Do you grind your teeth when asleep?	Y	N
Have your teeth been sore upon awakening?	Y	N	Are your jaws tired when you awaken from sleep?	Y	N
Does your jaw ache when you chew?	Y	N	When are your symptoms the worse?_____ Does anything make you feel better?_____		
Do you have ear pain?	Y	N	Have your wisdom teeth been extracted?	Y	N
Does your jaw ache when you open wide?	Y	N	What medications, if any are you taking?_____ _____		
Have you ever had chronic shoulder or back pain?	Y	N	How often do you take medication for relief of pain? a.) never b.) weekly to monthly c.) weekly d.) daily		
TRAUMA OR ACCIDENTS:					
Have you ever had a severe blow to the head or jaw?	Y	N	Have you ever been involved in any serious accidents, such as a car accident? Details:_____	Y	N
Any whiplash neck injuries?	Y	N			
JAW JOINT SYMPTOMS:					
Does your jaw feel tired after a big meal?	Y	N	Do you feel or hear clicking, popping or cracking noise from either jaw joint?	Y	N
Are there any foods you avoid eating?	Y	N	Has your jaw ever locked where you were unable to open or close?	Y	N
Do you ever get dizzy?	Y	N			
Do you ever feel faint?	Y	N	Do you have difficulty opening wide or yawning?	Y	N
Do you feel nauseated (sick)?	Y	N			
Is there a family history of jaw joint (TMJ)problems or headaches?	Y	N	Have you ever had pain in either jaw joint?	Y	N
EAR AND EYE SYMPTOMS:					
Do you have itchiness or stuffiness in either ear?	Y	N	Do you hear ringing, buzzing or hissing sounds in either ear?	Y	N
Do you suffer from any loss of hearing?	Y	N	Do you hear grating noises in ears? (like sand particles rubbing)	Y	N
Do you get pain in, around or behind either eye?	Y	N	Do you wear glasses or contact?	Y	N
			Does your eyesight blur?	Y	N
BREATHING:					
Do you have allergies?	Y	N	Is your nose stuffed when you don't have a cold?	Y	N
Do you have sinus problems?	Y	N			
Do you snore at night?	Y	N			

APPOINTMENT CANCELLATION AGREEMENT:

- **CREDIT CARD (Visa, Discover, Master Card, American Express)**

  Name on Card: _____

  Card # __ __ __ __ - __ __ __ __ - __ __ __ __ - __ __ __ __

  Exp: ___/___ CVV __ __ __

  Billing address: _____

  _____

  _____

  There will be a $75.00 charge to your card on file for any missed appointments or cancellations without a 24 hour notice.

Signature: _____ Drivers License #: _____ Date: _____

Signature of Legal Guardian (if patient is a minor):

_____