Anderson Family Dental
22106 Hwy 71 West
Spicewood, TX 78669

512.264.9977
www.AndersonDentalClinic.com
info@andersondentalclinic.com

Anderson Family Dental

Patient Information

Please take a moment to enter or update your information to help us ensure the quality of your care is excellent.

Patient Name: _____ (Last) _____ (First) _____ (MI) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) Gender: ☐ Male ☐ Female Family Status: ☐ Married ☐ Single ☐ Child ☐ Other

Birth Date: _____ Email Address: _____

Phone: _____ (Home) _____ (Work) _____ (Ext) _____ (Mobile) Best time to call: _____

Address: _____ (Street Address)

_____ (City) _____ (State) _____ (Zip Code)

Preferred Appointment Times:

☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday

☐ Morning ☐ Afternoon ☐ Any Time

Whom may we thank for referring you to our practice?

☐ Yellow Pages ☐ Internet ☐ Newspaper

☐ School ☐ Work ☐ Insurance

☐ Sign ☐ Patient (name below) ☐ Other (name below):

Name of person, office or other source referring you to our practice:

_____

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Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment ☐ neither-not applicable

Name: _____ (Last) _____ (First) _____ (MI) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) Gender: ☐ Male ☐ Female Family Status: ☐ Married ☐ Single ☐ Child ☐ Other

Birth Date: _____ Email Address: _____

Phone: _____ (Home) _____ (Work) _____ (Ext) _____ (Mobile) Best time to call: _____

Address: _____ (Street Address)

_____ (City) _____ (State) _____ (Zip Code)

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Phone: _____

Address: _____ (Street Address)

_____ (City) _____ (State) _____ (Zip Code)

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Dental Insurance Information

Primary Dental Insurance:

Name of Insured: _____ (Last) _____ (First) ____ (MI)

Insured Birth Date: _____ ID/SS # _____ Group # _____

Insured Address: _____ (Street Address)

_____ (City) ____ (State) _____ (Zip Code)

Insured's Employer Name: _____

Employer Address: _____ (Street Address)

_____ (City) ____ (State) _____ (Zip Code)

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insurance Plan Name: _____

Insurance Address: _____ (Street Address)

_____ (City) ____ (State) _____ (Zip Code)

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Health Information

Chart #: _____
FOR OFFICE USE ONLY

Date of Last Dental Visit: _____ Reason for this Visit: _____

Have you ever had any of the following? Please check those that apply:

- ☐ Abnormal Bleeding
- ☐ Alcohol Abuse
- ☐ AIDS or HIV+
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints/Heart Valve
- ☐ Asthma/COPD
- ☐ Bacterial Endocarditis
- ☐ Blood Disease
- ☐ Cancer
- ☐ Coumadin Patient
- ☐ Diabetes
- ☐ Dizziness
- ☐ Drug Abuse
- ☐ Epilepsy
- ☐ Fainting
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis A, B, C
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Mitral Valve Prolapse
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ **Pregnancy**
  Due Date: _____
- ☐ Radiation Treatment/Chemo
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Asprin Allergy
- ☐ Codeine Allergy
- ☐ Erythromycin Allergy
- ☐ Jewelry Allergy
- ☐ Latex Allergy
- ☐ Penicillin Allergy
- ☐ Sulfa Allergy
- ☐ Others:
  _____
  _____

Have you ever had any complication following dental treatment? ☐ Yes ☐ No

If yes, please explain: _____

Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No

If yes, please explain: _____

Are you now under the care of a physician? ☐ Yes ☐ No

If yes, please explain: _____

Name of Physician: _____ Phone: _____

Do you Currently Use Tobacco: _____

List all medications you are currently taking: _____

_____

Have you ever taken any bisphosphonates, a class of drugs used to treat osteoporosis or bone cancer? (Boniva, Fosamax, Actonel, Didronel, Skelid, Aredia, Zometa) ☐ Yes ☐ No

Do you have any health problems that need further clarification? ☐ Yes ☐ No

If yes, please explain: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ Date: _____
Signature of patient, parent or guardian

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WHAT IS YOUR IMMEDIATE CONCERN _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:	YES	NO
Personal History		
1. Are you fearful of dental treatment? Scale of 1 to 10 (very) _____	☐	☐
2. Have you had an unfavorable dental experience?	☐	☐
3. Have you ever had complications from past dental treatment?	☐	☐
4. Have you ever had trouble getting numb or reactions to local anesthetic?	☐	☐
5. Did you ever have braces, orthodontic treatment or had your bite adjusted?	☐	☐
6. Have you had any teeth removed?	☐	☐
Smile Characteristics		
7. Is there anything about the appearance of your teeth that you would like to change?	☐	☐
8. Have you ever whitened (bleached) your teeth?	☐	☐
9. Are you self conscious about your teeth?	☐	☐
10. Have you been disappointed with the appearance of previous dental work?	☐	☐
Bite and Jaw Joint		
11. Do you/would you have any problems chewing gum?	☐	☐
12. Do you/would you have any problems chewing bagels or other hard foods?	☐	☐
13. Have your teeth changed in the last 5 years, become shorter, thinner or worn?	☐	☐
14. Are your teeth crowding or developing spaces?	☐	☐
15. Do you have more than one bite or do you clench (squeeze) to make your teeth fit together?	☐	☐
16. Do you have problems with sleep or wake up with an awareness of your teeth?	☐	☐
17. Do you have any problems with your jaw joint? (pain, sounds, limited opening, locking, popping)	☐	☐
18. Do you have tension headaches or sore teeth?	☐	☐
19. Do you wear or have you ever worn a bite appliance?	☐	☐
Tooth Structure		
20. Have you had any cavities within the past 3 years?	☐	☐
21. Do you have a dry mouth?	☐	☐
22. Are any teeth sensitive to hot, cold, biting or sweets?	☐	☐
23. Have you ever had a toothache, cracked filing, broken, chipped or cracked tooth?	☐	☐
24. Do you avoid brushing any part of your mouth?	☐	☐
Gum and Bone		
25. Have you ever been diagnosed or treated for periodontal (gum) disease?	☐	☐
26. Have you ever experienced gum recession?	☐	☐
27. Is there anyone with a history of periodontal disease in your family?	☐	☐
28. Do your gums bleed when brushing, flossing or eating?	☐	☐
29. Are your teeth becoming loose?	☐	☐
30. Have you ever noticed an unpleasant taste or odor in your mouth?	☐	☐
31. Have you experienced a burning sensation in your mouth?	☐	☐

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

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Consent for Services

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time services are performed unless other arrangements are made.

Patients with dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I have read and understand the HIPAA policy.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment, or within five (5) days of billing if credit is extended. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me to discuss this statement or my treatment.

☐ I have read the above conditions of treatment and payment and agree to their content.

Signature of patient, parent, or guardian (responsible party):

Signature: _____ Date: _____

Relationship to Patient: _____

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OFFICE POLICIES

Thank you for choosing our office to provide your dental care. We appreciate your trust and look forward to working with you. In order to prevent any misunderstanding and to better serve you, we ask that all patients read and sign our OFFICE POLICIES. If you have any questions, please ask the front desk.

1. **VERIFYING INSURANCE:** **As a courtesy to you**, we will verify your insurance for eligibility benefits prior to your new patient appointment as well as any time that you notify us of a change in your coverage. The insurance companies do not guarantee payment based on the information that they provide us. **You are ultimately responsible** for knowing if there are any waiting periods for work to be performed. Any amounts on your treatment plans that are not covered by your insurance, are your financial responsibility.

2. **PAYMENT:** Payment is due **at the time of service.** Additionally, if you have a balance following an insurance payment from a previous visit, you will be expected to pay that amount as well.

3. **INSURANCE INFORMATION:** **New Insurance** as well as **changes in INSURANCE** must be provided to this office prior to an appointment. Failure to provide correct and current insurance information may result in the entire bill being **your** responsibility.

4. **CHANGES IN PERSONAL INFORMATION:** Changes in your address or telephone numbers should be kept current with our office.

5. **REQUESTS FOR ADDITIONAL INFORMATION:** These must be responded to **immediately.** Such requests include proof of a college student's full-time status and proof of continued enrollment in an insurance plan. Failure to provide this information to the insurance company in a timely manner may result in the entire balance being **your** responsibility.

6. **PAYMENT PLANS:** Our office offers Third Party Financing if needed to assist you in paying for any necessary treatment.

7. **BALANCES:** If your account balance exceeds 30 days, you will receive a notice informing you that your account is **overdue.** If you do not pay your balance or arrange a payment plan within 10 days, your account will be turned over to a collections agency. If this happens, a **collection fee** (currently 39% of the balance) will be added to your account balance. The collection agency will report any unpaid balance to the major credit bureaus.

8. **RETURNED CHECKS:** There will be a **$30** fee for all returned checks. The amount of the check plus the fee must be paid within10 days of notification by money order, cash or credit card. Once a check has been returned, this office will no longer accept personal checks for payment.

9. **CANCELLATIONS / FAILED APPOINTMENTS:** We request **24-hours notice** if you are cancelling an appointment. There will be a **$35** fee for cancellations made without 24 hours notice and for failed appointments ("no shows"). The $35 will be posted to your account, and you will not be allowed to make any other appointments for yourself or your family members until it is **paid in full.**

*** Thank you for reading this information in full. Please sign below to acknowledge your understanding of the OFFICE POLICIES ***

Patient or Guardian Signature _____ Date _____

Patient Name (Please Print) _____

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Consent for Internet Communications

Patient Name:				
	Last	First	MI	Preferred Name

I grant my permission to the dental practice to upload and store confidential patient information (including account information, appointment information and clinical information) to the secured web site for the dental practice. I understand that, for security purposes, the site requires a user ID and password for access and use. I also understand the dental practice and I are responsible for maintaining the strict confidentiality of any ID and password assigned to me; and that the dental practice is not liable for any charges, damages, or losses that may be incurred or suffered as a result of my failure to maintain confidentiality. I understand the dental practice is not liable for any harm related to the theft of my ID and password, my disclosure of my ID and password, or my authorization to allow another person or entity to access and use the dental practice web site with my ID and password. I also agree to immediately notify the dental practice of any unauthorized use of my ID or any other need to deactivate my ID due to security concerns.

Would you prefer to be contacted via phone, text or email? _____