Kurt Anderson, D.D.S., M.S.
Specialist in Orthodontics
3000 Moores Lane • Texarkana, TX 75503
(903) 794-2826 • (800) 782-2826
www.texarkanabraces.com

Patient # _____

Patient Information

Date _____ Age _____ Sex M / F

Patient's Name _____
Last First Middle

Residence _____
Street City State Zip

Mailing Address _____
Street City State Zip

How long at this address _____ Home Phone _____ Work Phone _____

Previous address (if less than 3 yrs.) _____
Street City State Zip

Cell Phone _____ Birthdate _____ Social Security # _____

Employer _____ Occupation _____ No. Years Employed _____

Email _____ Have we treated other family members? _____

What is your chief concern? _____

Whom may we thank for referring you to our office? _____

Who is your general dentist? _____

Spouse Information

Name _____
Last First Middle

Address _____
Street City State Zip

Mailing Address _____
Street City State Zip

Employer _____ Occupation _____ No. Years Employed _____

Social Security # _____ Birthdate _____ Work Phone _____

Insurance Information

Insured's Name _____ Date of Birth _____ Social Security # _____

Insurance Co. _____ Group No. _____ Employer _____

Ins. Co. Address _____ Ins. Co. Phone _____

Do you have dual coverage? ❒ Yes ❒ No

Insured's Name _____ Date of Birth _____ Social Security # _____

Insurance Co. _____ Group No. _____ Employer _____

Ins. Co. Address _____ Ins. Co. Phone _____

I hereby authorize payment directly to Kurt Anderson, D.D.S., M.S. of the group insurance benefits otherwise payable to me.

Signature _____ Date _____

Emergency Information

Name of nearest relative not living with you _____

Complete address _____

Phone _____ Alternate Phone _____

Continued on other side

Medical Information

Yes	No		Yes	No		Yes	No	
❒	❒	Heart Disease	❒	❒	Mononucleosis	❒	❒	Are you aware of any other disease, condition, or problem not listed above that we should know about?
❒	❒	Blood Disease	❒	❒	Prolonged Bleeding			If yes, what: _____
❒	❒	Thyroid Disease	❒	❒	Rheumatic/Yellow/Scarlet Fever			_____
❒	❒	Bone Disease	❒	❒	Rheumatism or Arthritis			_____
❒	❒	Emotional or Nervous Problems	❒	❒	Tuberculosis			_____
❒	❒	Endocrine Problems	❒	❒	Are you under Medical Care			_____
❒	❒	Problems with Wound Healing	❒	❒	Are you in Good Health			_____
❒	❒	Asthma	❒	❒	Women: Are you pregnant			List any medications: _____
❒	❒	Diabetes	❒	❒	Do you smoke or use tobacco			_____
❒	❒	Epilepsy	❒	❒	Have you ever taken bisphosphonates?			_____
❒	❒	Heart Murmur	❒	❒	Are you Allergic to Anything			_____
❒	❒	Hemophilia			If yes, what: _____			_____
❒	❒	Hepatitis			_____			_____
❒	❒	HIV Positive			_____			_____
❒	❒	Mitral Valve Prolapse			_____			_____
❒	❒	Artificial Joints or Heart Valves			_____			

Dental History

Yes	No	
❒	❒	Have you seen a General Dentist in the last year
❒	❒	Has the Mouth, Face or Teeth been Injured by a Fall or Accident
❒	❒	Have You Been Informed of Missing or Extra Permanent Teeth
❒	❒	Are You Aware of Any “Gum” or Periodontal Problems
❒	❒	Has a Physician or Dentist Advised Antibiotics Before a Dental Exam
❒	❒	Have your Tonsils or Adenoids Been Removed
❒	❒	Any Clicking or Popping of the Jaw
❒	❒	Any Jaw Discomfort or Pain

Do You Have or Ever Had Any of the Following Habits:

Yes	No	
❒	❒	Thumb Sucking
❒	❒	Finger Nail Biting
❒	❒	Clenching or Grinding Teeth
❒	❒	Tongue Thrusting
❒	❒	Speech Problems
❒	❒	Have You Been Examined by an Orthodontist Before? If Yes, when: _____

I certify that the information on this form is correct. I understand that it is my responsibility to report any changes and that where appropriate, credit bureau reports may be obtained.

Signature of Patient _____

Updates (date and initial)_____ _____ _____ _____ _____

For Office Use Only

		BP HR