Kurt Anderson, D.D.S., M.S.

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	Patient	Information			
Date			Sex M / F		
Patient's Name					
Address	Last	First	Middle		
	Street Birthdate		al Security #	Zip	
If patient is a minor, give pa	rent's or guardian's name that pa	atient lives with			
Have we treated other famil	y members? Please List.				
What is your chief concern?					
Whom may we thank for ref	erring you to our office?				
Dentist Name		Physician Nam	e		
School Name			Grade		
Custodial Parent or Guardian Information					

Name _____ Last Marital Status First Middle Residence _____ Street City State Zip Mailing Address Street City State Zip How long at this address Home Phone Work Phone Cell phone _____ Email Previous address (if less than 3 yrs.) City State Zip _____ Relationship to Patient _ Social Security # _____ Birthdate ____ __Occupation_ _____ No. Years Employed __ Employer ____ Spouse's Name – Relationship to Patient ______ First Middle ____ Occupation ___ Employer _ _ No. Years Employed __ Work Phone _____ Birthdate Social Security # ____ Cell Phone

	nsurance Information				
Insured's Name	Date of Birth	Social Security #			
Insured's Address if different from above		Insured's Phone			
Insurance Co	Group No	Employer			
Ins. Co. Address		Ins. Co. Phone			
Do you have dual coverage?)				
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	

Patient #_____

Modical Information

Yes	No		Yes	No		Yes No	
		Heart Disease			Mononucleosis	□ □ Are you aware of any other	
		Blood Disease			Prolonged Bleeding	disease, condition, or problem not listed above that we should know about?	
		Thyroid Disease			Rheumatic/Yellow/Scarlet Fever		
		Bone Disease			Rheumatism or Arthritis	If yes, what:	
		Emotional or Nervous Problems			Tuberculosis		
		Endocrine Problems			Is Patient under Medical Care		
		Problems with Wound Healing			Is the Patient in Good Health		
		Asthma			Women: Are you pregnant		
		Diabetes			Do you smoke or use tobacco	List any medications:	
		Epilepsy			Has the Patient Reached Puberty		
		Heart Murmur			Is the Patient Allergic to Anything		
		Hemophilia			If yes, what:		
		Hepatitis					
		HIV Positive					
		Mitral Valve Prolapse					
		Artificial Joints or Heart Valves					
	Dental History						
Yes							
		Have You Been Informed of Missing o	r Ext	ra Pe	ermanent Teeth	Suckina	

- □ □ Are You Aware of Any "Gum" or Periodontal Problems
- □ □ Has a Physician or Dentist Advised Antibiotics Before a Dental Exam □ □ Clenching or Grinding Teeth
- □ □ Have the Patient's Tonsils or Adenoids Been Removed
- Any Clicking or Popping of the Jaw
- □ □ Any Jaw Discomfort or Pain

- Thumb Sucking
- Finger Nail Biting
- **Tongue Thrusting**
- Speech Problems
- □ □ Has the Patient Been Examined by an Orthodontist

_____ Date _____

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 Custodial Parent or Guardian	

Updates (date and initial)_____

For Office Use Only					
		BP	HR		