Name: ______________________________ Date: ______________

Birthdate: ______________ M/F: ______ Marital Status: ____________

Address: ____Zip:______________

Home Phone: ______________Office Phone: ______________Cell Phone: ______________

E-mail Address: ______________________ Employer: ______________________

PERSON RESPONSIBLE FOR ACCOUNT

Name: __________________ Address: __________________ Zip: ______

DENTAL INSURANCE

Insurance Company: ____________________ Policy Holders Name: ________________

Policy Number: ____________________ Policy Holders Social Security#: ____________

Policy Holder Employer: ____________________ Policy Holders Birthdate: ______________

Whom May We Thank For Referring You: ____

Present Dental Complaint? ____________________ Previous Dentist: ________________

MEDICAL AND DENTAL HISTORY

HAVE YOU EVER HAD:	YES	NO
Hepatitis or Liver Disease	___	___
Joint Replacement	___	___
Rheumatic Fever	___	___
Diabetes	___	___
High/Low Blood Pressure	___	___
Heart Trouble	___	___
Heart Murmur	___	___
A.I.D.S.	___	___

ARE YOU:	YES	NO
If female are you now pregnant	___	___
Aware of grinding or clenching your teeth day or night	___	___
Interested in whitening your teeth	___	___
Presently under the care of a physician	___	___

ANY ALLERGIC REACTION TO:		
Latex	___	___
Anesthetics	___	___
Codeine	___	___
Penicillin	___	___
Sulfa Drugs	___	___
Aspirin	___	___

Other: ____________________

What medications are you now taking: ________________
____

Any serious illness not listed: ______________________

Any other concerns: ______________________

I hereby authorize Dr Bradley R Anderson to furnish information to insurance carriers concerning my treatment and I hereby assign to the dentist all payment for dental services rendered to myself or my dependents. I understand I am responsible for any amount not covered by the insurance. In order to provide the best care at the lowest cost, payment is due at the time of service including insurance co-pays and deductibles. Unpaid balances will be subject to a service charge of 1.5% per month and annual rate of 18%. I agree to pay all collection, attorney and / or interest fees acquired if necessary to collect on this amount.

Date: ______________ Signature: ____________________