

Number _____

HUGH R. PHILLIS, D.M.D.

Specialist in Orthodontics and Dentofacial Orthopedics

Welcome to our practice!

Please take a few minutes to complete these questions so that we may serve you better.



Personal Information

Date _____

Name _____ Birthdate _____ / _____ / _____
Last First Initial Month Day Year
Address _____ City _____ State _____ Zipcode _____

Home Phone _____ Work Phone _____ E-Mail _____

Employer _____ Address _____ City _____ State _____ Zipcode _____

Marital Status (Circle) Single Married Separated Divorced Widowed Sex (Circle) M F

Spouse _____ Birthdate _____ / _____ / _____
(If applicable) Last First Initial

Spouse _____
Employer _____ Address _____ City _____ State _____ Zipcode _____

Home Phone _____ Work Phone _____ Soc. Sec. No. _____ - _____ - _____

Financial Responsibility and Insurance Information

Person Responsible for Account _____ Relationship to you (Circle) Self Spouse Other _____

Address _____ City _____ State _____ Zipcode _____
(Complete if different from above)

Employer _____ Address _____ State _____ Zipcode _____
(Complete if different from above)

Insurance Company _____ Address _____ State _____ Zipcode _____

Insurance Phone _____ Insured's Soc. Sec. No. _____ - _____ - _____ Insured's Birthdate _____ / _____ / _____

Insurance Group No. _____ Orthodontic Coverage (Circle) Yes No Unsure Limits _____ % _____ Lifetime

2nd Insurance Company _____ Address _____ State _____ Zipcode _____

2nd Insur. Phone _____ Ortho. Coverage (Circle) Yes No Unsure Limits _____ % _____ Lifetime

2nd Insured's Name _____ 2nd Insured's Birthdate _____ / _____ / _____
Last First MI Mo. Day Yr.

2nd Group No. _____ 2nd Insured's Soc. Sec. No. _____ - _____ - _____

Please Complete Medical and Dental History on back!

Patient Dental Information

Dentist _____ Approximate Date of Last Visit _____
How did you hear about our office? _____

Toothbrushing Schedule per Day (Circle) 1X 2X 3X 4+ Flossing (Circle) Yes No Daily Infrequently

Areas of Concern (Circle all that apply):

Crowding Protrusion Cross-bite Missing Teeth Extra Teeth
Jaw Soreness Gum Problems Speech Problems Bite Off Slow Eruption Adult Teeth

History of the following (Circle all that apply):

Trauma to Teeth/Face Mouthbreathing Snoring Tongue Thrust
Finger/Thumb Sucking Grinding Clenching Headaches/Earaches
Clicking by ear when open Jaw gets stuck open/closed Pain in Jaw Joint Previous orthodontic treatment
Family pattern of bite problem (Explain) _____

Patient Medical History

Physician _____ Approximate Date of Last Visit _____

Currently on Medication: (Circle) Yes No If Yes, List _____

Any History of Allergies or Allergic Reaction to the following (Circle all that apply):

Penicillin or other Antibiotics Sulfa Drugs Aspirin Tylenol(Acetaminophen)
Advil(Ibuprophen) Latex Nickel Local Anesthetics(Novocaine)
Pollen/Seasonal Animals Foods (List) _____

Medical and Disease History (Circle all that apply):

AIDS/HIV Positive Anemia Arthritis Artificial Heart Valves/Joints
Asthma Back/Neck Problems Bleeding Problem Blood Disease (list) _____
Cancer Chemotherapy Cold Sores Congenital Heart Murmur/Problems
Diabetes Epilepsy Emotional Problems Hepatitis (list type) _____
Kidney Problems Liver disease/Jaundice Migraines Under Care of Psychologist/Psychiatrist
Radiation Treatment Rheumatic Fever Skin problems/Rashes Stroke
Tuberculosis Venereal Disease Vision/Hearing DeficiencyOther _____

Other Concerns

To get the best result, orthodontic treatment relies on good patient cooperation (i.e. good brushing, wearing elastics, not breaking braces loose from teeth, not eating hard or sticky foods). With this in mind, is there anything that would prevent this type of cooperation?

(Please circle) Yes No
If yes, please explain _____

Orthodontic treatment also uses diagnostic x-rays prior to treatment and during treatment to monitor treatment response and dental health, would you like (please circle the following):

Take appropriate x-rays as necessary Inform prior to taking any film Take no x-rays

Authorization

I have completed this form fully. The information provided is complete and correct. I agree to inform this office of any change(s) at the next visit. I permit use of the patient records for presentation at scientific meetings. I acknowledge that the financially responsible person named above is responsible for all charges and balances remaining after insurance. I permit review of my credit history for preparation of financial arrangements. I acknowledge receipt of "notice of privacyPractices".

Signature _____