

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. *(Please Print)*



### Patient Information

Date \_\_\_\_\_

Patient Name \_\_\_\_\_ Birthdate \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Last First Initial Month Day Year  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zipcode \_\_\_\_\_

Patient's Home Phone \_\_\_\_\_ E-Mail \_\_\_\_\_ Patient's Sex (Circle) M F

Your Name \_\_\_\_\_ Relationship to Patient (Circle) Parent Step-Parent Other \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zipcode \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ E-Mail \_\_\_\_\_

Your Employer \_\_\_\_\_ Address \_\_\_\_\_ State \_\_\_\_\_ Zipcode \_\_\_\_\_

Your Marital Status (Circle) Single Married Separated Divorced Widowed Other \_\_\_\_\_

Spouse \_\_\_\_\_ Work Phone \_\_\_\_\_  
(If applicable) Last First Initial

Spouse Employer \_\_\_\_\_ Address \_\_\_\_\_ State \_\_\_\_\_ Zipcode \_\_\_\_\_

### Financial Responsibility and Insurance Information

Person Responsible for Payment \_\_\_\_\_ Relationship to Patient (Circle) Parent Step-Parent 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 \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Mo. Day Yr.

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

Person with 2<sup>nd</sup> Insurance Name \_\_\_\_\_ Relationship to Patient (Circle) Parent Step-Parent Other \_\_\_\_\_  
Last First MI

2<sup>nd</sup> Insurance Company \_\_\_\_\_ Address \_\_\_\_\_ State \_\_\_\_\_ Zipcode \_\_\_\_\_

2<sup>nd</sup> Insurance Phone \_\_\_\_\_ 2nd Insured's Soc. Sec. No. \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ 2nd Insured's Birthdate \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Mo. Day Yr.

2<sup>nd</sup> Insurance Group No. \_\_\_\_\_ Ortho. Coverage (Circle) Yes No Unsure Limits \_\_\_\_\_ % \_\_\_\_\_ Lifetime

**Please Complete Medical and Dental History on back!**

# Patient Dental Information

Dentist \_\_\_\_\_ Approximate Date of Last Visit \_\_\_\_\_

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/Earchaches  
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 Deficiency Other \_\_\_\_\_

# 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 Privacy Practices".

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Print Name