PHILLISORTHODONTICS

Number_____

Dr. Stephanie Phillis-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*_____/_____/_____
First Last Initial Month Day Year

*Address*_____ *City*_____*State*_____*Zipcode*_____

*Patient's Phone #:*_____ *Email*_____*Patient's Sex (Circle) M F X*[nonbinary]

*Your Name*_____*Relationship to Patient (Circle) Parent Step-Parent Other*_____
(if different from patient's)

*Your Address*_____ *City*_____ *State*_____*Zipcode*_____
(if different from patient's)

Your Cell Phone #: _____*E-Mail*_____

*Your Employer*_____*Address*_____ *State*_____*Zipcode*_____

*Your Marital Status (Circle) Single Married Separated Divorced Widowed Other*_____

*Spouse/Partner's Name*_____*Spouse/Partner's Phone Number*_____
(If applicable) First Last

Financial Responsibility and Dental Insurance Information

*Person Responsible for Payment*_____*Relationship to Patient:*_____
(if different from patient's)

*Address*_____*City*_____*State*_____*Zipcode*_____
(if different from patient's)

*Employer*_____ *Address*_____*State*_____*Zipcode*_____
(if different from patient's)

*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 2nd Insurance Name*_____ *Relationship to Patient (Circle) Parent Step-Parent Other*_____
Last First MI

*2nd Insurance Company*_____*Address*_____*State*_____*Zipcode*_____

*2nd Insurance Phone*_____ *2nd Insured's Soc. Sec. No.*_____-_____-_____ 2nd Insured's Birthdate_____/_____/____
Mo. Day Yr.

*2nd Insurance Group No.*_____ Ortho. Coverage (Circle) Yes No Unsure Limits_____%_____Lifetime

Please Complete Medical and Dental History on back!

Patient Dental Information

Dentist:_____Est. Date of Dentist Appointment_____

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	Mouth-breathing	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*_____*Est. Date of Last Visit*_____

Currently on Medication: *(Circle) Yes No* Please list medications*:*_____

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

Penicillin or other Antibiotics	*Sulfa Drugs*	*Aspirin*	*Tylenol(Acetaminophen)*
Advil(Ibuprofen)	*Latex*	*Nickel*	*Local Anesthetics(Lidocaine)*
Pollen/Seasonal	*Animals*	*Foods (List)*_____	*Other:*_____

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 cp	*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 ONE OF 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 acknowledge receipt of "Notice of Privacy Practices".

_____ _____ _____

Signature *Print Name* *Date*