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 #*_____ *Work #*_____*Cell #*_____ *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!