 **Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

#### Dr. Hugh R. Phillis & Dr. Stephanie Phillis-Specialists in Orthodontics and Dentofacial Orthopedics

(Hugh R. Phillis, DMD PA)

***Welcome to our practice!*** Please take a few minutes to complete these questions so that we mayserve 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 Xnonbinary

## 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 ID #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_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 ID #\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 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 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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Bone Disorders/Osteoporosis/Osteopenia Bisphosphonates/bone medication (past or present)*

**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 permit review of my credit history for preparation of financial arrangements. I acknowledge receipt of “Notice of Privacy Practices”.*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Signature Print Name Date*