phillips ORTHODONTICS

Changing lives one smile at a time

Tell Us About You

Today's Date: ____/____/____

Full Name: _____ I prefer to be called: _____

Physical Address: _____ City: _____ State: _____ ZIP: _____

Mailing Address *(if different)*: _____ City: _____ State: _____ ZIP: _____

Birth Date: ____/____/____ Age: _____ ☐ Male ☐ Female How long at current address? _____

SS# _____ DL# _____ e-mail _____

Home #: _____ Work #: _____ Cell #: _____ Cell provider: _____

Employer: _____ Occupation: _____

How long at current job? _____ When / where are best times to reach you? _____

Who may we thank for referring you? _____

Have we seen any of your family members? _____

General Dentist: _____ Last Visit Date: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Partnered ☐ Separated

Spouse Information

Name: _____ Birth Date: ____/____/____

Employer: _____ Occupation: _____

Work #: _____ How long at current job? _____

SS#: _____ DL#: _____ Cell # _____ Cell provider: _____

Dental Insurance Information

Primary Insurance Company Name: _____

Policy Owner's Name: _____ Relationship to Patient: _____

Policy Owner's Birth date: ____/____/____ ID #: _____ Employer: _____

Secondary Insurance Company Name: _____

Policy Owner's Name: _____ Relationship to Patient: _____

Policy Owner's Birth date: ____/____/____ ID #: _____ Employer: _____

In case of emergency, please list a contact person other than your spouse.

Name: _____ Relation: _____

Work #: _____ Home #: _____

Dental History

What are your main concerns that you would like orthodontics to accomplish? _____

_____

Have you ever been evaluated or had orthodontic treatment before? ☐ Yes ☐ No If so, when? _____

Have you ever had a serious / difficult situation associated with any previous dental work? ☐ Yes ☐ No

Please explain: _____

How would you describe your current dental health? ☐ Good ☐ Fair ☐ Poor

Do you like your smile? ☐ Yes ☐ No Do your gums ever bleed? ☐ Yes ☐ No

Have there been any injuries to the face, mouth, teeth or chin? ☐ Yes ☐ No If so, please describe: _____

_____

Have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)? ☐ Yes ☐ No

Have you ever been informed of any missing or extra permanent teeth? ☐ Yes ☐ No

Do you have any speech problems? _____

Do you generally breathe through your mouth? ☐ Yes ☐ No If so, while asleep or awake? *(please circle one)*

Do you use tobacco of any kind? ☐ Yes ☐ No

Health History

Are you currently under the care of a physician? ☐ Yes ☐ No

Physician's Name: _____ Phone #: _____ Last visit: _____

Please explain: _____

Ladies, are you pregnant? ☐ Yes ☐ No How many weeks? _____ Are you nursing? ☐ Yes ☐ No

Please list any medications that you are currently taking? _____

Describe your current physical health: ☐ Good ☐ Fair ☐ Poor

Have you ever had any of the following medical diseases or medical problems?

☐ Yes	☐ No	Abnormal Bleeding	☐ Yes	☐ No	Anemia	☐ Yes	☐ No	Artificial Bones / Joints / Valves
☐ Yes	☐ No	Asthma	☐ Yes	☐ No	Arthritis	☐ Yes	☐ No	Blood Transfusion
☐ Yes	☐ No	Cancer / Chemotherapy	☐ Yes	☐ No	Congenital Heart Defect	☐ Yes	☐ No	Diabetes
☐ Yes	☐ No	Difficulty Breathing	☐ Yes	☐ No	Drug / Alcohol Abuse	☐ Yes	☐ No	Emphysema
☐ Yes	☐ No	Epilepsy / Seizures / Fainting	☐ Yes	☐ No	Fever Blisters / Herpes	☐ Yes	☐ No	Glaucoma
☐ Yes	☐ No	Heart Attack / Stroke	☐ Yes	☐ No	Heart Murmur	☐ Yes	☐ No	Heart Surgery / Pacemaker
☐ Yes	☐ No	Hemophilia	☐ Yes	☐ No	Hepatitis	☐ Yes	☐ No	High / Low Blood Pressure
☐ Yes	☐ No	HIV+ / AIDS	☐ Yes	☐ No	Hospitalization	☐ Yes	☐ No	Kidney Problems
☐ Yes	☐ No	Mitral Valve Prolapse	☐ Yes	☐ No	Psychiatric Problems	☐ Yes	☐ No	Radiation Treatment
☐ Yes	☐ No	Rheumatic / Scarlet Fever	☐ Yes	☐ No	Severe Headaches	☐ Yes	☐ No	Shingles
☐ Yes	☐ No	Sickle Cell Disease	☐ Yes	☐ No	Sinus Problems	☐ Yes	☐ No	Tuberculosis
☐ Yes	☐ No	Ulcers / Colitis	☐ Yes	☐ No	Venereal Disease			

Please list any serious medical condition(s) that you have ever had: _____

_____

Are you allergic to any of the following?

☐ Yes	☐ No	Aspirin	☐ Yes	☐ No	Dental Anesthetics	☐ Yes	☐ No	Penicillin
☐ Yes	☐ No	Any Metals / Plastics	☐ Yes	☐ No	Erythromycin	☐ Yes	☐ No	Tetracycline
☐ Yes	☐ No	Codeine	☐ Yes	☐ No	Latex	☐ Yes	☐ No	Other

Please list any other drugs / materials that you are allergic to: _____

_____

_____

I understand that the information that I have provided is correct to the best of my knowledge, and that HIPAA guidelines will be followed regarding this information. I also understand that it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary dental services that I may need.

_____

Signature Date

If this office accepts assignment of benefits for my insurance, I authorize payment directly to Daniel. S. Phillips, DMD, PC. If this office does not accept assignment of benefits of my insurance, I understand that the insurance payments will come directly to the insured member, and I will be responsible for reimbursing the office. I am ultimately responsible for any fees or deductibles that are not covered by my insurance plan.

_____

Signature Date

This office reserves the right to verify the credit status of financially responsible parties prior to extending credit for treatment fees, and may use the services of a credit reporting institution.

_____

Signature Date

OFFICE USE ONLY

I verbally reviewed the medical / dental information above with the patient named herein. Initials _____ Date _____

Doctor's Comments: _____

_____

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ORTHODONTICS

PRIVACY NOTICE ACKNOWLEDGEMENT (HIPAA)

This is a summary of our office's privacy policy. You will see that we have posted a detailed policy statement in the reception area. We will be happy to provide you with the detailed policy statement if you wish.

Our staff is trained in preserving the privacy of your protected health information. We will only share this information as needed for the purposes of treatment, payment, and administrative operation of the office. If we need to share your protected information for other reasons (i.e. research) we will discuss this with you and ask for written consent.

As our office is small, our staff members are cross-trained and will have access to your protected information. They will utilize information only as permitted by law. Any breach of our policy will involve appropriate actions.

Should you have any questions regarding your privacy, please address your concerns to Daniel S. Phillips, DMD. If you feel a complaint is warranted, you may file one in writing with the above listed names. As noted under HIPAA regulations, there will be no retaliatory action against patients wishing to exercise their rights under these guidelines.

Patient Name(s):_____

I have received a copy of the Privacy Notice for this organization on today's date.

Signed: _____ Date: _____

By Signing below, you authorize the following people to receive information regarding your treatment and/or financial information:

Name: _____Relationship:_____

Approval Signature: _____ Date: _____

☐ Treatment ☐ Financial

If patient is unable to acknowledge receipt, staff member providing notice to complete this section

The Privacy Notice was provided to Patient Name:_____ On _____

The patient was unable to acknowledge receipt of the Privacy Notice for the following reason:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency prevented us from obtaining acknowledgement
- ☐ Other (please specify)_____

Signed: _____ Date: _____