Date: _____

PHILLIPS ORTHODONTICS

New Patient Form

I. Patient

Title: _____ Last name: _____ First name: _____ Middle initial: _____

Date of Birth: _____ Sex: ☐ Male ☐ Female Social Security #: _____

II. Account Holder

Title: _____ Last name: _____ First name: _____ Middle initial: _____

Date of Birth: _____ Social Security #: _____

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

Home address: _____

City: _____ State: _____ Zip Code: _____

Home phone: (___)_____ Cell phone: (___)_____ Work phone: (___)_____

Email Address(es): _____

Relationship to Patient _____ Employer _____

III. Closest Relative to Account Holder

Spouse or closest relatives name(s): _____

Title: _____ Relationship to Account Holder: _____

Address *(if different than patient address):* _____

Home phone: (___)_____ Cell phone: (___)_____ Work phone: (___)_____

IV. Dentist

Patient's Dentist: _____ City, State: _____

Last seen: _____ Reason: _____ Next appointment: _____

V. Referrer

Referral Name: _____ City, State: _____

VI. Dental Insurance (Insurance claim forms will be generated for patient/account holder to submit)

Primary policy holder's full name: _____

Home address: _____

City: _____ State: _____ Zip Code: _____

Social Security #: _____ Date of Birth: _____

Employer: _____ Address: _____

Does this policy have orthodontic benefits? Yes ☐ No ☐ Don't Know ☐

Secondary policy holder's full name: _____

Home address: _____

City: _____ State: _____ Zip Code: _____

Social Security #: _____ Date of Birth: _____

Employer: _____ Address: _____

Does this policy have orthodontic benefits? Yes ☐ No ☐ Don't Know ☐

VII. General Information

What concerns you about your teeth? _____

Who suggested that you might need orthodontic treatment? _____

Why did you select our office? _____

Have any other family members been treated in this office? Please name them. _____

Have you had any previous orthodontic treatment? Please describe. _____

VIII. Dental History

Do you feel pain in any of your teeth? _____

Do you clench or grind your teeth? _____

Do you bite your lips or cheeks frequently? _____

Do your gums bleed while brushing or flossing? _____

Are your teeth sensitive to hot, cold, sweet, or sour liquids/foods? _____

Do you have pain or soreness in muscles of the face or around the ears? _____

IX. Medical History

Your answers are for office records only and are confidential. A thorough medical history is essential to a complete orthodontic evaluation.

Has the patient recently (within past year) visited or received treatment from a physician Yes ☐ No ☐

For what? _____

Now or in the past, have you had:

Y ☐ N ☐ Birth defects or hereditary problems?

Y ☐ N ☐ Bone fractures or major injuries?

Y ☐ N ☐ Any injuries to face, head, neck?

Y ☐ N ☐ Arthritis or joint problems

Y ☐ N ☐ Endocrine or thyroid problems?

Y ☐ N ☐ Diabetes or low sugar?

Y ☐ N ☐ Kidney problems?

Y ☐ N ☐ Cancer, tumor, radiation treatment or chemotherapy?

Y ☐ N ☐ Stomach ulcer, hyperacidity, acid reflux?

Y ☐ N ☐ Immune system problems?

Y ☐ N ☐ History of osteoporosis?

Y ☐ N ☐ Sexually transmitted diseases?

Y ☐ N ☐ AIDS or HIV positive?

Y ☐ N ☐ Hepatitis, jaundice, or other liver problems?

Y ☐ N ☐ Mononucleosis, tuberculosis, pneumonia?

Y ☐ N ☐ Seizures, fainting spells, neurologic problems?

Y ☐ N ☐ Mental health disturbance or depression?

Y ☐ N ☐ Vision, hearing, or speech problems?

Y ☐ N ☐ History of eating disorder (anorexia, bulimia)?

Y ☐ N ☐ High or low blood pressure?

Y ☐ N ☐ Excessive bleeding or bruising, anemia?

Y ☐ N ☐ Chest pain, shortness of breath, tire easily, swollen ankles?

Y ☐ N ☐ Heart defects, heart murmur, rheumatic heart disease?

Y ☐ N ☐ Angina, arteriosclerosis, stroke or heart attack?

Y ☐ N ☐ Skin disorder (other than common acne)?

Y ☐ N ☐ Frequent headaches or migraines?

Y ☐ N ☐ Frequent ear infections, colds, throat infections?

Y ☐ N ☐ Asthma, sinus problems, hayfever?

Y ☐ N ☐ Tonsil or adenoid condition?

Y ☐ N ☐ Do you frequently breathe through your mouth?

Other:_____

For women:

Y ☐ N ☐ Are you pregnant or trying to become pregnant?

Doctor Initials: _____

Have you had allergies or reactions to any of the following?

Y ☐ N ☐ Local anesthetics (novocaine, lidocaine, xylocaine)

Y ☐ N ☐ Latex (gloves, balloons)

Y ☐ N ☐ Aspirin

Y ☐ N ☐ Metals (jewelry, clothing snaps)

Y ☐ N ☐ Penicillin

Y ☐ N ☐ Other antibiotics

Y ☐ N ☐ Ibuprofen (Motrin, Advil)

Y ☐ N ☐ Acrylics

Y ☐ N ☐ Animals

Y ☐ N ☐ Foods

Y ☐ N ☐ Other substances

Explain: _____

Doctor Initials: _____

Medications

Medication: _____ Taken for: _____

Medication: _____ Taken for: _____

Medication: _____ Taken for: _____

Have you ever taken any medications to strengthen your bones? Please describe. _____

Do you take antibiotic pre-medication before any dental procedures? _____

Do you or have you ever had a substance abuse problem? _____

Do you chew or smoke tobacco? _____

Have you noticed any changes in your face or jaws? _____

Any other physical problems? _____

X. Release and Waiver

I authorize release of any information regarding my orthodontic treatment to my dental and/or medical insurance company.

Signature _____ Date: _____

I have read the above questions and understand them. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. I will notify my orthodontist of any changes in my medical or dental health.

Signature _____ Date: _____

I understand that records are stored electronically and that an electronic copy shall be considered an original for all purposes.

Initials: _____ Date: _____

XI. Consent to Dental Photography

I, _____ (Patient/Parent), authorize Dr. Carson Phillips to take photographs, and/or videos of my face, jaws and teeth, before, during and after treatment. I consent to allow the photographs to be used for the following: Orthodontic records, Orthodontic research, and Orthodontic education

I further understand that if the photographs and/or videos are used, my name or other identifying information will be kept confidential.

I do not expect compensation, financial or otherwise, for the use of these photographs.

Signature (Patient/Parent) _____ Date _____