WELCOME TO OUR PRACTICE Today's date_____

PATIENT INFORMATION

Name_____ (Preferred name?) _____ M___F___

Soc Sec No_____ Date of birth_____

Marital status: ___married ___single ___widowed ___minor ___divorced ___separated

Address_____City_____Zip_____

Home phone(___)_____Cell(___)_____Accept texts? Y_____ N_____

Email_____ Preferred method of contact? _____

Employer_____ Work phone (___)_____

Work address_____ City_____Zip_____

Spouse or parent's name_____ Work phone(___)_____

Person to contact in an emergency_____Phone(___)_____

How did you choose our office? _____

RESPONSIBLE PARTY

Name of person responsible for this account_____Relation_____

Address_____City_____Zip_____

Soc Sec No _____Date of birth_____

Employer _____Work phone(___)_____

Home phone(___)_____Cell(___)_____Email_____

DENTAL INSURANCE INFORMATION (complete section below OR present insurance card)

Name of insured_____Relation to patient_____

Member ID# or SSN _____Date of birth_____

Employer _____How long? _____Work phone(___)_____

Employer address_____City_____Zip_____

Insurance Co _____Group #_____

Address_____City_____State_____Zip_____

SECONDARY DENTAL INSURANCE (if applicable)

Name of insured_____Relation to patient_____

Member ID # or SSN _____Date of birth_____

Employer_____ How long? _____Work phone(___)_____

Employer address_____City_____Zip_____

Insurance Co_____ Group #_____

Address_____City_____State_____

(OVER)

DENTAL HISTORY

Reason for dental visit _____Date of last dental exam_____

Please mark with an "x" all that apply to you:

___Bleeding gums	___Sensitivity to cold	___Sensitivity when biting	___Loose teeth
___Clicking or popping jaw	___Sensitivity to hot	___Sores/growths in mouth	___Broken fillings
___Grinding or clenching teeth	___Sensitivity to sweets	___Periodontal treatment	___Bad breath

How often do you brush? _____How often do you floss?_____

MEDICAL HISTORY

Physician's name _____Date of last visit_____

List medications you are taking_____

List any allergies to medications/anesthetics_____

Have you ever used a bisphosphonate medication (Fosamax, Actonel, Atelvia, Didronel, Boniva) Yes_____ No_____

List any operations or serious illnesses in the last 5 years_____

(Women) Are you pregnant? Y_____ N_____ Nursing? Y_____ N_____ Taking birth control pills? Y_____ N_____

Please mark with an "x" all that apply to you:

___Anemia	___Circulatory problems	___Hemophilia	___Scarlet fever
___Arthritis/rheumatism	___Congenital heart lesions	___Hepatitis	___Shortness of breath
___Artificial heart valve(s)	___Cortisone treatments	___High blood pressure	___Skin rash
___Artificial joints	___Cough, persistent	___HIV/AIDS	___Stroke
___Asthma/emphysema	___Coughing up blood	___Jaw pain	___Swelling of feet/ankles
___Back problems	___Diabetes	___Kidney disease	___Thyroid problems
___Bleeding abnormality	___Epilepsy	___Liver disease	___Tobacco habit
___Blood disease	___Fainting	___Mitral valve prolapse	___Tonsillitis
___Cancer	___Headaches	___Pacemaker	___Tuberculosis
___Chemical dependency	___Heart murmur	___Radiation treatment	___Ulcer
___Chemotherapy	___Heart problems	___Rheumatic fever	___Venereal disease

___Other_____

AUTHORIZATION AND RELEASE

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

I certify that I, and/or my dependent(s), have insurance coverage with_____Insurance Company, and assign directly to Dr. Daniel Phillips all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above named dentist may use my health care information and may disclose such information to the above named insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

_____ _____

Signature of patient, parent, guardian or personal representative Date

Printed name_____ Relationship to patient_____