PATIENT INFORMATION

First Name:_____MI:_____Last:_____ Preferred Name:_____

Home Phone:_____Work Phone:_____Cell Phone:_____

Date of Birth:_____ □ Male □ Female Social Security #:_____

Address:_____City:_____State:_____Zip:_____

Employer:_____

E-mail Address (This will be used to remind you to schedule a cleaning appointment):

_____ _____

Preferred contact method: (circle one) Phone E-mail Text Mail

EmergencyContact:_____Relationship:_____Phone:_____

PATIENT HEALTH HISTORY

Do you have a history of: (circle Yes or No)

AIDS/HIV	Yes	No	Hearing Impaired	Yes	No	Latex Sensitivity	Yes	No
Asthma	Yes	No	Heart Disease	Yes	No	Mitral Valve Prolapse	Yes	No
Cancer	Yes	No	Hepatitis	Yes	No	Pacemaker	Yes	No
Diabetes	Yes	No	High Blood Pressure	Yes	No	Seizures	Yes	No
Excessive Bleeding	Yes	No	Joint Replacement	Yes	No	Venereal Disease	Yes	No
Osteoporosis	Yes	No						

MEDICAL QUESTIONS

List any medications you are taking including nonprescription drugs and injections:

_____

_____

Please list any allergies:

_____

Have you ever had any complications following dental treatment? If yes, please explain:

_____

Have you suffered from a heart attack or stroke in the past 6 months?_____

Do you have any artificial joints or any other condition that might require premedication? (For example: knee replacement, hip replacement, etc.)_____

Are you currently taking or have you taken medicines by mouth or by injection for osteoporosis, bone loss, or bone density? (This would include injections given to you at your doctor's office.) YES NO

Are you currently taking or have you taken chemotherapy? YES NO

FOR WOMEN ONLY:		
Are you taking birth control pills?	Yes	No
Are you pregnant?	Yes	No
Are you nursing?	Yes	No

(NOTE: Antibiotics may alter the effect of birth control pills)

I certify that I have read and understand the questions above. To the best of my knowledge, all of the preceding answers and information provided are true and correct. I will not hold my dentist or any other members of his/her staff responsible for any errors that I have made in completion of this form.

Adult/Guardian: I hereby consent to treatment, including anesthetics and x-rays, as deemed necessary by the treating dentist. I understand that, in order to properly diagnose cavities, broken teeth, etc., x-rays are required at least every 12 months.

Patient:_____ **Date:**_____

Parent/Guardian (if patient is under 19 years old):_____
Relationship to patient:_____

MEDICAL RELEASE

We cannot talk to anyone in your family about your dental care without your consent. If you would like for us to talk to a family member concerning your care or if you would like for a family member to be able to pick up forms for you (for example: end of the year tax forms), please list those family members and sign below.

I authorize Travis P. Phillips, DMD, LLC to release my personal dental information to the following individuals:

_____

_____

Patient Signature:_____ Date:_____

PAYMENT ARRANGEMENT

Name of Patient:_____

Dental estimates are provided to you prior to treatment so that you may know what to expect at the time treatment is rendered. However, please know that THIS IS ONLY AN ESTIMATE and estimates expire after 6 months from the date of the examination. Any amount that is not covered by your insurance company is your responsibility and must be paid promptly. As soon as the response/payment is received from your insurance company, a statement will be mailed to you and payment is due immediately.

By signing below, I agree with the statements above and I further agree to pay all costs of collection and attorney/court fees if I default on the agreement. I understand that Travis P. Phillips, DMD, LLC may charge: 1) a late fee if payment on my account is not received by the due date; 2) an amount equal to $30.00 for each returned check; and 3) a fee for each appointment missed without notice. I further agree to be contacted by a representative of Travis P. Phillips, DMD, LLC regarding my treatment and/or financial matters via text, e-mail or phone at any and all of the phone numbers and/or e-mail addresses provided by myself on this form.

I authorize Travis P. Phillips, DMD, LLC to accept assignment of benefits with my insurance company and I authorize payment directly to Travis P. Phillips, DMD, LLC.

I acknowledge having received a copy of the HIPAA Privacy Policy, as established by Travis P. Phillips, DMD, LLC.

Patient Signature:_____Date:_____

Parent/Guardian(if patient is under 19 years old):_____

Relationship to patient:_____ Date of Birth:_____ Date:_____

Address of parent/guardian:_____

INSURANCE INFORMATION

It is the responsibility of the patient or guardian to provide correct insurance information. Please note: If you have more than one insurance, it is your responsibility to update coordination of benefits with BOTH insurance companies prior to your treatment. Claims cannot be filed until this is completed.

Name of insurance cardholder:_____

Date of birth of insurance cardholder:_____Relationship to patient:_____

Social Security # of insurance cardholder:_____

Place of employment of insurance cardholder:_____

Home Phone:_____Cell:_____Work:_____

Name of insurance company:_____Contract #:_____