Chart #:_____
FOR OFFICE USE ONLY

Patient Information

Patient Name: _____ Date:_____
Last First MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date:_____

Phone (Home): _____ (Work): _____ Ext:_____ Cell number_____

E-mail Address: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Person to contact in emergency_____ Phone_____

Health Information

Date of Last Dental Visit: _____ Reason for this visit:_____

Have you ever had any of the following? Please check those that apply:

☐ AIDS
☐ Allergies _____
_____
☐ Anemia
☐ Arthritis
☐ Artificial Joints
☐ Asthma
☐ Blood Disease
☐ Cancer
☐ Diabetes
☐ Dizziness
☐ Epilepsy
☐ Excessive Bleeding
☐ Fainting
☐ Glaucoma
☐ Growths
☐ Hay Fever
☐ Head Injuries
☐ Heart Disease
☐ Heart Murmur
☐ Hepatitis
☐ High Blood Pressure
☐ Jaundice
☐ Kidney Disease
☐ Liver Disease
☐ Mental Disorders
☐ Nervous Disorders
☐ Pacemaker
☐ Pregnancy
Due date:_____
☐ Radiation Treatment
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Rheumatism
☐ Sinus Problems
☐ Stomach Problems
☐ Stroke
☐ Tuberculosis
☐ Tumors
☐ Ulcers
☐ Venereal Disease
☐ Codeine Allergy
☐ Penicillin Allergy
OTHER:
☐ _____
☐ _____

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain:_____
- Have you suffered from a heart attack OR stroke in the past 6 months?_____
- Do you have mitral valve prolapse?_____

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

*PLEASE NOTIFY US IF YOU ARE TAKING ANY MEDICATION FOR OSTEOPOROSIS OR CHEMOTHERAPY. THIS INCLUDES ANY INJECTIONS FOR BONE DENSITY.

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ Date: _____
Signature of patient, parent or guardian

Please list any medications you are currently taking:

_____
_____
_____

Please list any medical allergies you may have:

_____
_____
_____

Information for Insured (insurance policyholder)

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext:_____ Cell Number _____

Address: _____
Street Apartment #

_____
City State Zip Code

Employment Information

Patient's Employer:_____

Insured's (if different from patient)Employer:_____

Medical Release

I hereby acknowledge that I have received an updated copy of the HIPAA Privacy Policy, as established by Travis P. Phillips, DMD. Further, I hereby authorize Travis P. Phillips, DMD to release my personal dental information to the following individuals:

_____

_____

_____

_____

Signed this the _____day of _____, 20____

Signature of Patient:_____

CONSENT TO TREAT AND FINANCIAL AGREEMENT

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 it is ONLY an estimate. Any amount that is not covered by your insurance company is your responsibility and must be paid promptly. As soon as a response/payment is received from your insurance company, a statement will then be mailed to you and payment is due immediately. Balances older than 30 days may be subject to additional collection fees. Also know that estimates can only be extended for a period of six months from the date of the patient examination.

We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

We do offer Care Credit. If interested, please ask our front desk personnel and they will be happy to help you.

By signing below, I am giving my consent for treatment and I understand the above document and I further agree to pay all costs of collection and attorney fees if I default on the agreement. I further agree to be contacted by a representative of Travis P. Phillips, D.M.D., L.L.C. regarding my treatment and/or financial matters at any and all phone numbers provided by myself on this form.

_____ Date: _____
Signature of patient

_____ Date: _____
Signature of parent or guardian (if under 19 years of age)
Relationship to patient:_____