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 (not living in your household)________________________ 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 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.

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 allergies you may have:

____
____

Information for Insured (subscriber of insurance)

Name: ____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other ________________

Social Security #: ______________________________ Birth Date: ______________________________

Phone (Home): _______________ (Work): _______________ Ext:______ Cell Number ________________

Address: ____

Street Apartment #

____

City State Zip Code

Information for Parent Responsible for Payment (person signing this form) if Patient is Under 18 years of age

Name:____

Phone(Home):____________________ (Work):________________________ (Cell):_________________________

Birth Date:______________________ Relationship to Patient:____________________________________

Address:____

Street Apartment #

____

City State Zip Code

Employment Information

Patient's Employer:____

Insured's 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 prior to treatment so that you may know what to expect at the time of payment. However, please know that it is ONLY an estimate. Any amount that is not covered by your insurance company is your responsibility and 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.

____ Date: _____________

Signature of patient

____ Date: _____________

Signature of parent or guardian (if under 18 years of age)