Allan S. Phillips D.D.S, PC

PATIENT INFORMATION

Date ___/___/___

Patient Name _____ Nickname _____
First Middle Last

If Patient is Child, Parents Name _____

Address _____
Street City State Zip Code

Home Phone (___)_____ Work Phone (___)_____ Sex M F Age ____ Date of Birth ___/___/___

Dentist _____ Physician _____

Who Referred you to our practice? _____

PATIENT HEALTH HISTORY

Does the patient have or ever had:

Rheumatic Fever	___	Mental Disorders	___	Diabetes	___	Bleeding Tendency	___
Heart Condition	___	Speech Problems	___	Anemia	___	Epilepsy	___
Heart Murmur	___	Hepatitis	___	Allergies	___	HIV	___

Reaction to any Drugs? _____ Other _____

Are you currently taking any medications? _____

Are you or could you be pregnant? _____

Do you have any brothers or sisters? _____ Ages _____

In your own words, please describe the orthodontic problem as you see it. _____

_____

_____

Does anyone else in the family have a similar dental or facial condition? _____

_____

If so please describe. _____

Has anyone else in the family received orthodontic care? Yes ___ No ___

If yes, was the patient treated in this office? Yes ___ No ___

Have the teeth of the patient ever been injured? Yes ___ No ___

What was the cause of the accident? _____

_____

How old was the patient at time of accident or injury? _____ Which teeth were involved? _____

If the patient has any of the following habits please check:

Lip Sucking	____	Thumb or Finger Sucking	____	Lip Biting	____
Grinding	____	Tongue Thrusting	____	Nail Biting	____

Has the patient had any unfavorable experience at a dental or medical office? _____

If yes, please explain _____

_____

PRIMARY RESPONSIBLE PARTY INFORMATION

1st Responsible Party Name _____

Address _____
Street

_____
City State Zip Code

Home Phone (___)_____ Work Phone (___)_____

Married ___ Single ___ Widowed ___ Divorced ___

Relationship to Patient _____

Insurance Company _____

Address _____
Street

_____
City State Zip Code

SSN _____-_____-_____ Occupation _____

2nd Responsible Party Name _____

Address _____
Street

_____
City State Zip Code

Home Phone (___)_____ Work Phone (___)_____

Married ___ Single ___ Widowed ___ Divorced ___

Relationship to Patient _____

Insurance Company _____

Address _____
Street

_____
City State Zip Code

SSN _____-_____-_____ Occupation _____