Jim Phillips, Jr., D.M.D.

Family and Cosmetic Dentistry

Welcome! Please take a few minutes to fill out this form front and back. If you have any questions, we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Patient Information

Date _____

Name (Last)_____(First)_____(MI)_____Preferred Name _____

Sex ❑M ❑F Age _____ Birthdate_____Social Security No._____

Address _____

City _____ State_____ Zip _____

Home Phone_____ Cell_____ Preferred # to call during the day _____

Email Address _____Martial Status _____

Are you a full time student? ❑Yes ❑No If so, where? _____

Employed by _____Who may we thank for referring you to our office?_____

Spouses Name_____Employed by_____ Phone_____

In case of emergency, who should be notified? _____ Phone _____

Responsible Party Information

(If different from patient.)

Name (Last)_____(First)_____(MI)_____Martial Status_____

Relation to the Patient _____ Birthdate _____ Soc. Sec. No. _____

Address _____City_____State_____Zip_____

Home Phone_____Cell Phone_____Drivers License #_____

Employed by_____Work Phone_____

Dental Insurance

Is the patient covered by dental insurance? ❑Yes ❑No

If yes, we would like to make a copy of your insurance card.

Subscriber's Name (Last)_____ (First)_____(MI)_____

Relation to the Patient _____ Birthdate _____ Soc. Sec. No. _____

Address *(if different from patient)* _____

City _____ State_____Zip _____ Phone _____

Employed By _____ Contract #: _____

Insurance Company _____ Group # _____ Insurance Co. Phone _____

Names of other dependents covered under this plan _____

Additional Dental Insurance

Is the patient covered by 2nd insurance? ❑Yes ❑No

If yes, we would like to make a copy of your insurance card.

Subscriber's Name (Last)_____(First)_____(MI)_____

Relation to the Patient _____ Birthdate _____ Soc. Sec. No. _____

Dental History

Reason for Today's Visit_____

Check (✔) if you have had problems with any of the following:

- ❑ Bad breath
- ❑ Bleeding gums
- ❑ Clicking or popping jaw
- ❑ Food collection between teeth
- ❑ TMJ Problems
- ❑ Grinding teeth
- ❑ Loose teeth or broken fillings
- ❑ Periodontal treatment
- ❑ Sensitivity to cold
- ❑ Missing Teeth
- ❑ Sensitivity to hot
- ❑ Sensitivity to sweets
- ❑ Sensitivity to when biting
- ❑ Sensitivity or growths in your mouth
- ❑ Stained or discolored teeth

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

Former Dentist_____

Address _____

City_____ State_____ Zip_____Phone _____

Date of last dental care_____ Date of last dental X-rays _____

Medical History

Physician's Name _____ Date of Last Visit _____

Have you had any serious illnesses or operations? ❑Yes ❑No If yes, describe _____

_____

Are you allergic to latex? ❑Yes ❑No Have you ever had a reaction to jewelry or metals? ❑Yes ❑No

(Women) Are you pregnant? ❑Yes ❑No If yes, approximate due date _____

Check (✔) if you have had problems with any of the following:

- ❑ Aids
- ❑ Anemia
- ❑ Arthritis, Rheumatism
- ❑ Artificial Heart Valves
- ❑ Artificial Joints
- ❑ Asthma
- ❑ Back Problems
- ❑ Blood Disease
- ❑ Cancer
- ❑ Chemical Dependency
- ❑ Chemotherapy
- ❑ Circulatory Problems
- ❑ Cortisone Treatment
- ❑ Cough, Persistent
- ❑ Cough Up Blood
- ❑ Diabetes
- ❑ Epilepsy
- ❑ Fainting
- ❑ Glaucoma
- ❑ Headaches
- ❑ Heart Murmur
- ❑ Heart Problems
- ❑ Describe _____
- ❑ Hemophilia
- ❑ Hepatitis
- ❑ High Blood Pressure
- ❑ HIV Positive
- ❑ Jaw Pain
- ❑ Kidney Disease
- ❑ Liver Disease
- ❑ Mitral Valve Prolapse
- ❑ Nervous Problems
- ❑ Pacemaker
- ❑ Psychiatric Care
- ❑ Radiation Treatment
- ❑ Respiratory Disease
- ❑ Sensitivity to hot
- ❑ Scarlet Fever
- ❑ Shortness of Breath
- ❑ Skin Rash
- ❑ Stroke
- ❑ Feet or Ankle Swelling
- ❑ Thyroid Problems
- ❑ Tobacco Habit
- ❑ Tonsillitis
- ❑ Tuberculosis
- ❑ Ulcer
- ❑ Venereal Disease

MEDICATIONS *(list any medications you are currently taking including OTC):*

_____

_____

ALLERGIES

_____

_____

I authorize my insurance company to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize the dentist to release all information to secure the payment of benefits. I give Dr. Phillips and his staff authorization to contact me at any/all of the phone numbers (including the cell #) for the purpose of treatment, insurance or payment.

I understand that I am financially responsible for all charges whether or not paid by insurance. Uncollected balances are subject to finance charges, collection fees, and any additional costs related to the collection process. If a check is returned, there will be a returned check fee assessed for a minimum of $30.00.

Signature _____ Date _____

Payment is due in full at the time of treatment unless prior arrangements have been approved.