

Laura Philipps, D.M.D

Comprehensive Restorative and Esthetic Dentistry

Patient Name: _____ E-mail: _____

Home Address: _____ City: _____ State: _____ Zip code: _____

Phone #'s: Home: _____ Cell: _____ Work: _____ Ext: _____

Birth Date: ___/___/___ Social Security # _____ Gender: Male Female

Family Status: Married Single Child Other

Employment Information

The following is for: the patient the responsible party

Employer Name: _____ Phone#: _____ Ext: _____

Spouse or Responsible Party Information

The following is for: the patient's spouse the responsible party

Name: _____ Gender: Male Female

Family Status: Married Single Child Other

Birth Date: ___/___/___ Social Security # _____ Spouse Employer: _____

Phone #'s: Home: _____ Cell: _____ Work: _____ Ext: _____

Home Address: _____ City: _____ State: _____ Zip code: _____

Primary Dental Insurance Plan Name: _____ Employer: _____

Full Name of Insured: _____ Insured's Birth Date: ___/___/___

Insurance ID#. _____ Group#. _____ Insurance Phone #. _____

Relationship to Insured: Self Spouse Child Other

Is there any secondary insurance? Yes No Drivers License #. _____

I hereby authorize my insurance benefits to be paid directly to the dentist. I am financially responsible for any balances due and authorize the dentist to release any information for this claim.

Signature: _____ Print Name: _____ Date: ___/___/___

Please provide Insurance card and Drivers license for identity verification.

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Treatment Acceptance Form

I have disclosed my health history information, including allergies, reactions to medicine, diseases, and past procedures. I understand that withholding this information may affect the outcome of the procedure(s) or course(s) of treatment.

I authorize Dr. Philipps and any other qualified assistants or medical professionals to perform the procedure(s) or treatment(s). I also give my consent for these individuals to administer any needed medicine and to perform any compulsory life-saving procedures.

I authorize any necessary life-saving procedures to be performed in the event of an emergency during the procedure(s) or course(s) of treatment. I understand that a blood transfusion may be a part of a life-saving procedure and give my consent for necessary blood work. I give my consent for the administration of any medication that may be required as a life-saving measure.

As a condition of treatment by this office, financial arrangements must be made in advance. Patients with dental insurance understand that all dental services are charged directly to the patient and he or she is responsible for payment on all dental services. This office will help prepare the patient's insurance forms. However, this office cannot render services on the assumption that our charges will be paid by an insurance company. In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services rendered. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all cost and reasonable attorney fees if suit be instituted hereunder.

I confirm that I understand this form and the information contained therein.

I have read the above conditions of treatment and payment and agree to their content.

Signature of patient or responsible party:

Signature: _____ Date: _____

Print Name: _____

Relationship to Patient: _____

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Acknowledgement of Receipt of Privacy Practices

I _____ have received a copy of Laura Philipps, D.M.D Notice of Privacy Practices.
(Name of Patient)

(Patient Signature)

(Date)

I authorize the release of my information to the following:

Staff will fill out this section if Patient's signature is not obtained

Our office made a good faith effort to obtain Acknowledgement of Receipt of Privacy Practices, but it was not obtained for the following reason:

____ Patient refused to sign

____ Emergency situation kept us from obtaining the patient's signature

____ Language barriers kept us from obtaining the patient's signature

____ Other situation: _____

DENTAL HISTORY

Name _____ Nickname _____ Age _____
Referred by _____ How would you rate the condition of your mouth? Excellent Good Fair Poor
Previous Dentist _____ How long have you been a patient? _____ Months/Years
Date of most recent dental exam ____/____/____ Date of most recent x-rays ____/____/____
Date of most recent treatment (other than a cleaning) ____/____/____
I routinely see my dentist every: 3 mo. 4 mo. 6 mo. 12 mo. Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING: YES NO

PERSONAL HISTORY

1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [____] _____
2. Have you had an unfavorable dental experience? _____
3. Have you ever had complications from past dental treatment? _____
4. Have you ever had trouble getting numb or had any reactions to local anesthetic? _____
5. Did you ever have braces, orthodontic treatment or had your bite adjusted? _____
6. Have you had any teeth removed? _____

GUM AND BONE

7. Do your gums bleed or are they painful when brushing or flossing? _____
8. Have you ever been treated for gum disease or been told you have lost bone around your teeth? _____
9. Have you ever noticed an unpleasant taste or odor in your mouth? _____
10. Is there anyone with a history of periodontal disease in your family? _____
11. Have you ever experienced gum recession? _____
12. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? _____
13. Have you experienced a burning sensation in your mouth? _____

TOOTH STRUCTURE

14. Have you had any cavities within the past 3 years? _____
15. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? _____
16. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? _____
17. Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth? _____
18. Do you have grooves or notches on your teeth near the gum line? _____
19. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? _____
20. Do you frequently get food caught between any teeth? _____

BITE AND JAW JOINT

21. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) _____
22. Do you feel like your lower jaw is being pushed back when you bite your teeth together? _____
23. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods? _____
24. Have your teeth changed in the last 5 years, become shorter, thinner or worn? _____
25. Are your teeth becoming more crooked, crowded, or overlapped? _____
26. Are your teeth developing spaces or becoming more loose? _____
27. Do you have more than one bite, squeeze, or shift your jaw to make your teeth fit together? _____
28. Do you place your tongue between your teeth or rest your teeth against your tongue? _____
29. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? _____
30. Do you clench your teeth in the daytime or make them sore? _____
31. Do you have any problems with sleep (i.e. restlessness), wake up with a headache or an awareness of your teeth? _____
32. Do you wear or have you ever worn a bite appliance? _____

SMILE CHARACTERISTICS

33. Is there anything about the appearance of your teeth that you would like to change? _____
34. Have you ever whitened (bleached) your teeth? _____
35. Have you felt uncomfortable or self conscious about the appearance of your teeth? _____
36. Have you been disappointed with the appearance of previous dental work? _____

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

MEDICAL HISTORY

Patient Name _____ Nickname _____ Age _____
 Name of Physician/and their specialty _____
 Most recent physical examination _____ Purpose _____
 What is your estimate of your general health? Excellent Good Fair Poor

- | | | | | | |
|--|------------|-----------|--|------------|-----------|
| DO YOU HAVE or HAVE YOU EVER HAD: | YES | NO | | YES | NO |
|--|------------|-----------|--|------------|-----------|
1. hospitalization for illness or injury _____
 2. an allergic reaction to
 - aspirin, ibuprofen, acetaminophen, codeine
 - penicillin
 - erythromycin
 - tetracycline
 - sulfa
 - local anesthetic
 - fluoride
 - metals (nickel, gold, silver, _____)
 - latex
 - other _____
 3. heart problems, or cardiac stent within the last six months _____
 4. history of infective endocarditis _____
 5. artificial heart valve, repaired heart defect (PFO) _____
 6. pacemaker or implantable defibrillator _____
 7. orthopedic implant (joint replacement) _____
 8. rheumatic or scarlet fever _____
 9. high or low blood pressure _____
 10. a stroke (taking blood thinners) _____
 11. anemia or other blood disorder _____
 12. prolonged bleeding due to a slight cut (INR > 3.5) _____
 13. emphysema, shortness of breath, sarcoidosis _____
 14. tuberculosis, measles, chicken pox _____
 15. asthma _____
 16. breathing or sleep problems (i.e. sleep apnea, snoring, sinus) _____
 17. kidney disease _____
 18. liver disease _____
 19. jaundice _____
 20. thyroid, parathyroid disease, or calcium deficiency _____
 21. hormone deficiency _____
 22. high cholesterol or taking statin drugs _____
 23. diabetes (HbA1c = _____) _____
 24. stomach or duodenal ulcer _____
 25. digestive disorders (i.e. celiac disease, gastric reflux) _____
 26. osteoporosis/osteopenia (i.e. taking bisphosphonates) _____
 27. arthritis _____
 28. autoimmune disease _____
(i.e. rheumatoid arthritis, lupus, scleroderma)
 29. glaucoma _____
 30. contact lenses _____
 31. head or neck injuries _____
 32. epilepsy, convulsions (seizures) _____
 33. neurologic disorders (ADD/ADHD, prion disease) _____
 34. viral infections and cold sores _____
 35. any lumps or swelling in the mouth _____
 36. hives, skin rash, hay fever _____
 37. STI / STD / HPV _____
 38. hepatitis (type _____) _____
 39. HIV / AIDS _____
 40. tumor, abnormal growth _____
 41. radiation therapy _____
 42. chemotherapy, immunosuppressive medication _____
 43. emotional difficulties _____
 44. psychiatric treatment _____
 45. antidepressant medication _____
 46. alcohol / recreational drug use _____
- ARE YOU:**
47. presently being treated for any other illness _____
 48. aware of a change in your health in the last 24 hours
(i.e. fever, chills, new cough, or diarrhea) _____
 49. taking medication for weight management _____
 50. taking dietary supplements _____
 51. often exhausted or fatigued _____
 52. experiencing frequent headaches _____
 53. a smoker, smoked previously or use smokeless tobacco _____
 54. considered a touchy / sensitive person _____
 55. often unhappy or depressed _____
 56. FEMALE - taking birth control pills _____
 57. FEMALE - pregnant _____
 58. MALE - prostate disorders _____

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment.
 (i.e. Botox, Collagen Injections)

List all medications, supplements, and or vitamins taken within the last two years.

Drug	Purpose	Drug	Purpose
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature _____ Date _____
 Doctor's Signature _____ Date _____