RONALD G. PHILIPP, D.M.D.

2525 Center Point Pkwy.
Birmingham, AL 35215

ADULT

PATIENT INFORMATION Date ________

PATIENT

Name: ________ FIRST ________ MIDDLE ________ LAST
Address: ________
City: ________ State: ____ Zip: ____
Home Phone: ________ Work Phone: ________
Cell Phone: ________
Birthday: ________ Age: ____ Sex: ____ Marital Status: ____
Driver's License #: ________ S.S.#: ________
Checking Acct. #: ________

EMPLOYER INFORMATION

Employer Name: ________
Employer Address: ________
City: ________ State: ____ Zip: ____
Occupation: ________

SPOUSE

Name: ________ FIRST ________ MIDDLE ________ LAST
Address: ________
City: ________ State: ____ Zip: ____
Home Phone: ________ Work Phone: ________
Cell Phone: ________
Birthday: ________ Age: ____ Sex: ____ Marital Status: ____
Driver's License #: ________ S.S.#: ________
Checking Acct. #: ________

EMPLOYER INFORMATION

Employer Name: ________
Employer Address: ________
City: ________ State: ____ Zip: ____
Occupation: ________

BILLING INFORMATION

Responsible Party

Name: ________ Phone: ________
Address: ________ City: ________ State: ____ Zip: ____

INSURANCE INFORMATION

Primary Insurance Co. Name: ________ Orthodontic Coverage? ❑ Yes ❑ No
Insurance Co. Address: ________
Phone #: ________ Group #: ________ Contract #: ________
Policy Owner's Name: ________ SS#: ________
Policy Owner's Birthdate: ____ / ____ / ____ Employer: ________ Relationship to Patient: ________

Secondary Insurance Co. Name: ________ Orthodontic Coverage? ❑ Yes ❑ No
Insurance Co. Address: ________
Phone #: ________ Group #: ________ Contract #: ________
Policy Owner's Name: ________ SS#: ________
Policy Owner's Birthdate: ____ / ____ / ____ Employer: ________ Relationship to Patient: ________

OTHER INFORMATION

How Did You Hear About Our Office? ________
Dentist Name: ________ Address: ________ Phone: ________
Physician Name: ________ Address: ________ Phone: ________

MEDICAL INFORMATION

Check (✓) if you have or have had any of the following:

Condition		
Frequent or Severe Headaches	☐ YES	☐ NO
Any Heart Disease	☐ YES	☐ NO
Any Sinus or Respiratory Disease	☐ YES	☐ NO
Any Blood Disease	☐ YES	☐ NO
Any Liver Disease	☐ YES	☐ NO
Any Thyroid Disease	☐ YES	☐ NO
Any Kidney Disease	☐ YES	☐ NO
H.I.V. Positive	☐ YES	☐ NO
Any Venereal Disease	☐ YES	☐ NO
Any Intestinal Disease	☐ YES	☐ NO
Any Bone Disease	☐ YES	☐ NO
Any Nervous/Emotional Problems	☐ YES	☐ NO
Any High or Low Blood Pressure	☐ YES	☐ NO
Any Endocrine Problems	☐ YES	☐ NO
Any Problems with Wounds Healing	☐ YES	☐ NO
Any Tumors or Cancer	☐ YES	☐ NO
Tonsillitis/Frequent Sore Throats	☐ YES	☐ NO
Any Joint Problems	☐ YES	☐ NO
Rheumatic/Yellow/Scarlet Fever	☐ YES	☐ NO
Acquired Immune Deficiency Syndrome	☐ YES	☐ NO
Is Patient Under Medical Care?	☐ YES	☐ NO
Rheumatism or Arthritis	☐ YES	☐ NO
Is Patient Taking any Medications?	☐ YES	☐ NO
A History of Fainting or Dizziness	☐ YES	☐ NO
Does Patient Have a Drug Addiction?	☐ YES	☐ NO
Is Patient Pregnant at this time?	☐ YES	☐ NO
Measles/Mumps/Chicken Pox	☐ YES	☐ NO
Has Patient Ever had Fever Blisters?	☐ YES	☐ NO
Is the Patient in Good Health?	☐ YES	☐ NO
Has Patient had a Physical This Year?	☐ YES	☐ NO
Heart Murmur	☐ YES	☐ NO
Mononucleosis	☐ YES	☐ NO
Hepatitis	☐ YES	☐ NO
Polio	☐ YES	☐ NO
Diabetes	☐ YES	☐ NO
Anemia	☐ YES	☐ NO
Hemophilia	☐ YES	☐ NO
Emphysema	☐ YES	☐ NO
Epilepsy	☐ YES	☐ NO
Asthma or Hay Fever	☐ YES	☐ NO
Tuberculosis	☐ YES	☐ NO
Prolonged Bleeding	☐ YES	☐ NO
Yellow Jaundice	☐ YES	☐ NO
Radiation Therapy	☐ YES	☐ NO
Chemical Therapy	☐ YES	☐ NO
Blood Transfusions	☐ YES	☐ NO
Latex Allergy	☐ YES	☐ NO

List Any Medications Currently Taking ______________________

____

Is the Patient Allergic to Anything? ☐ YES ☐ NO

If Yes, What? ______________________

Are you aware of any other disease, condition or problems not listed above that we should know about? ☐ YES ☐ NO

If Yes, What? ______________________

Check (✓) if you have any unusual reactions to the following: ☐ Aspirin ☐ Sulfa Drugs ☐ Barbiturates ☐ Penicillin

☐ Other Medications ______________________

Please Explain ______________________

DENTAL HISTORY

Question		
Has the Patient Seen a General Dentist in the Last Year?	☐ YES	☐ NO
Any Pain, Clicking or Discomfort in or Near the Ears?	☐ YES	☐ NO
Has the Mouth, Face or Teeth Been Injured by A Fall or Accident?	☐ YES	☐ NO
Have You Been Informed of Missing or Extra Permanent Teeth?	☐ YES	☐ NO
Are You Aware of Any "Gum" Problems?	☐ YES	☐ NO
Have the Patient's Tonsils or Adenoids Been Removed?	☐ YES	☐ NO
Do You Feel the Patient Can Benefit From Orthodontic Treatment?	☐ YES	☐ NO
Is the Patient Happy With Their "SMILE"?	☐ YES	☐ NO
Does the Patient Want to Improve Their "SMILE" and "BITE"?	☐ YES	☐ NO
Cheek, Tongue or Lip Chewing?	☐ YES	☐ NO
Thumb Sucking	☐ YES	☐ NO
Mouth Breathing	☐ YES	☐ NO
Fingernail Biting	☐ YES	☐ NO
Clenching Teeth	☐ YES	☐ NO
Tongue Thrusting	☐ YES	☐ NO
Grind Teeth	☐ YES	☐ NO
Speech Problems	☐ YES	☐ NO
Has the Patient Been Examined by an Orthodontist Before?	☐ YES	☐ NO

If Yes, When ______________________

Question		
Have Other Family Members Had Orthodontic Treatment?	☐ YES	☐ NO
If Yes, Were You Happy with the Results?	☐ YES	☐ NO

If No, Why ______________________

In Your Own Words, What is the Orthodontic Problem? ______________________

What Would You Like Orthodontic Treatment to Accomplish? ______________________

This information is accurate and true to the best of my knowledge. I understand that I am responsible to pay for services rendered, including reasonable attorney's fees and costs of collection in the event of default. I further understand that if payment becomes past due an annual rate of 18% or the maximum allowable rate, will be due on delinquent amounts from the date the payment is due.

______________________ ______________________

Patient Signature *Date*