

RONALD G. PHILIPP, D.M.D.

2525 Center Point Pkwy.
Birmingham, AL 35215

WORTHAMPTON DRIVE JACKSON

Date _____

PATIENT INFORMATION

CHILD

Name: _____ Address: _____
FIRST MIDDLE LAST
Phone: _____ Birthday: _____ City: _____ State: _____ Zip: _____
Height: _____ Weight: _____ Age: _____ Sex: _____

Father or Guardian Information

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

EMPLOYER INFORMATION

Employer Name: _____
Employer Address: _____
City: _____ State: _____ Zip: _____
Occupation: _____

Mother Information

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

EMPLOYER INFORMATION

Employer Name: _____
Employer Address: _____
City: _____ State: _____ Zip: _____
Occupation: _____

Patient Lives With Name: _____ Relationship: _____
Address: _____ Phone: _____

Responsible Party

BILLING INFORMATION

Name: _____ Phone: _____
Address: _____

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: _____
Sports or Hobbies: _____ School Name: _____
List Brothers / Sisters With Age: _____

MEDICAL INFORMATION

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

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

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