# Adult Medical History

**Patient Information**

| First Name * | Last Name * | Date of Birth * | Age * |
|---|---|---|---|
| | | / / | |

**Gender** ◯ Male ◯ Female ◯ Unknown

| Address * | City * | State * | Zip * |
|---|---|---|---|
| | | | |

| Home Phone * | Cell Phone * | Work Phone * | Ext * |
|---|---|---|---|
| ( ____) _____ - _____ | ( ____) _____ - _____ | ( ____) _____ - _____ | _____ |

**Preferred Method of Contact?** ◯ Phone ◯ Text/SMS ◯ Email

| Employer / School | Referral Source / How Did You Find Us? |
|---|---|
| | |

| Emergency Contact | Cell Number | Relationship |
|---|---|---|
| | (_____) _____-_____ | |

| Approximate Height | Approximate Weight |
|---|---|
| | LBS |

For sedation / medication purposes

Have you previously been or are currently under the care of a health care professional for any kind of specific condition or syndrome? ◯ YES ◯ NO

| Primary Care Provider | Phone Number | Reason |
|---|---|---|
| | (_____)_____-_____ | |

**Do you require premedication prior to hygiene (cleaning) appointment or dental treatment?**
Please be sure to take your premedication prior to your appointment.
◯ YES ◯ NO ◯ N/A

| Reason for the Pre-Medication | Doctor Prescribing Pre-Medication | Date of Operation |
|---|---|---|
| | | _____/_____/_____ |

**FEMALES**
Are you pregnant, nursing or a possibility you could be pregnant? ⚪ YES ⚪ NO

**Are you on a blood thinner?** ⚪ YES ⚪ NO ⚪ N/A

| Reason for Blood Thinner | Doctor Prescribing Blood Thinner | Phone Number |
|---|---|---|
| | | (_____) _____-_____ |

**Have you had any major surgeries?** ⚪ YES ⚪ NO ⚪ N/A

Please Explain:

**Are you taking any medications (including birth control, vitamins, etc)?** ⚪ YES ⚪ NO ⚪ N/A

Please Explain:

**Do you have any known allergies?** ⚪ YES ⚪ NO ⚪ N/A

Please Explain & List Reaction:

- ☐ Local Anesthetics _____
- ☐ Codeine _____
- ☐ Insulin _____
- ☐ Barbiturates _____
- ☐ Latex _____
- ☐ Metals _____
- ☐ Ibuprofen _____
- ☐ Penicillin _____
- ☐ Aspirin _____
- ☐ Iodine _____
- ☐ Other: _____

_____

**Do you have any of the following?**

- ☐ Anemia
- ☐ Stroke/Blood Clots
- ☐ Blood Transfusions
- ☐ Heart Disease
- ☐ Artificial Heart Valve
  - Date: _____/_____/_____
- ☐ Congenital Heart Defects
- ☐ Rheumatic Heart Disease
- ☐ Cancer
  - Date Diagnosed: _____/_____/_____
  - Type/Stage: _____
- ☐ Chemotherapy
- ☐ Radiation Therapy
- ☐ Drug/Alcohol Dependency
  - How Often: _____
- ☐ Mental Illness

| | |
|---|---|
| ☐ Angina<br>☐ Heart Attack<br>• Date: _____/_____/_____<br>☐ Chest Pain<br>☐ Pacemaker<br>• Date Placed: _____/_____/_____<br>☐ Tuberculosis<br>☐ Asthma<br>☐ Hay Fever<br>☐ Emphysema<br>☐ Pneumonia<br>☐ Pleurisy<br>☐ Thyroid/Adrenal Disease | ☐ Heart Murmur<br>☐ High Blood Pressure<br>☐ Rheumatoid Arthritis<br>☐ Eye Disorders<br>☐ Epilepsy<br>☐ Seizures<br>☐ Malignant Hyperthermia<br>☐ Kidney Disease<br>☐ DIabetes<br>☐ Smoker<br>• If Previous Smoker, Date Stopped: _____/_____/_____<br>☐ Pins, Plates, Replacement Joints<br>• Date: _____/_____/_____<br>• Replacement?:_____ |

# Adult Dental History

| Last Dental check-up/ cleaning? | How often do you see the Dentist? | How often do you brush your teeth? | How often do You floss your teeth? |
|---|---|---|---|
| | | | |

**Do you have any problems that require immediate attention?** ⚪ YES ⚪ NO ⚪ N/A

Please Explain:

| |
|---|
| |

**Do any of the following cause tooth discomfort?**

- ☐ Sweets
- ☐ Hot
- ☐ Cold
- ☐ Chewing

Do you clench or grind your teeth? ⚪ YES ⚪ NO ⚪ N/A

**Have you ever had orthodontic treatment? (Braces / Invisalign)**
⚪ YES ⚪ NO ⚪ N/A
If **'Yes'** : Orthodontist: _____ Phone #: (_____) _____ - _____

**Are you interested in straightening your teeth?** ⚪ YES ⚪ NO

**Have you ever considered:**
⚪ Straightening ⚪ Whitening ⚪ Crowns ⚪ Veneers

**Do you have spaces that you would like closed?** ⚪ YES ⚪ NO

**How do you feel about the appearance of your teeth & is there anything you would like to share/discuss about your smile?**

| |
|---|
| |

# HIPAA

*HIPAA is a federal law developed to give individuals the right to request a restriction on uses and disclosures of their Protected Health Information (PHI). The individual is also provided the right to request confidential communication of PHI that may be made by alternative means or correspondence.*
*The purpose of the Notice of Privacy Practice is to explain how Phillippi Dental may use or disclose your health care information. This Notice also explains the rights that you are guaranteed under HIPAA regulations. All information provided on this form is part of your Protected Health Information and will NEVER be shared with a 3rd party.*

**Patient Information**

First Name: Last Name: Date of Birth: / /

**Please provide us the best phone number(s) to contact you**

Home Phone: _____-_____-_____ Cell Phone: _____-_____-_____

Work Phone: _____-_____-_____ EXT: _____

**Please check the applicable box:**

- ☐ Would you like to be notified of and confirm appointments via text messages and/or email?
- ☐ May we call the phone number(s) above and leave detailed voice messages regarding your appointments, billing matters and / or medical information?
- ☐ Would you like to receive special offers or internal promotions via emails?

Please list the person(s) you give permission to us to disclose your appointments, billing matters or medical information with.

Name: Relationship:

Name: Relationship:

Name: Relationship:

***By signing below, I hereby acknowledge that I have received a copy of Phillippi Dental's Notice of Privacy Practice. I have read and understand this HIPAA privacy rule. I have also agreed to allow Phillippi Dental and the employees thereof to relay detailed messages regarding my appointments, billing matters and or medical information to myself or the above named representatives as specified.***

**Name of Signing Person: _____**

**Signature: _____ Date: _____/_____/_____**

# Dental Insurance & Financial Responsibility Authorization Form

| Patients First Name | Patients Last Name | Patients SS# |
|---|---|---|
| | | - - |

| Subscribers First Name | Subscribers Last Name | Subscribers Date of Birth |
|---|---|---|
| | | / / |

| Insurance Company | Insurance Phone Number | Insurance Address (including City, State, Zip) |
|---|---|---|
| | (_____) _____-_____ | |

| Employer | Group Number | Member ID/Certificate Number |
|---|---|---|
| | | |

Do you have Secondary Insurance? ⚪ YES ⚪ NO

| Subscribers First Name | Subscribers Last Name | Subscribers Date of Birth |
|---|---|---|
| | | / / |

| Insurance Company | Insurance Phone Number | Insurance Address (including City, State, Zip) |
|---|---|---|
| | (_____) _____-_____ | |

| Employer | Group Number | Member ID/Certificate Number |
|---|---|---|
| | | |

## Insurance & Fee-For-Service Authorization

I understand and acknowledge that **Phillippi Dental is a fee-for-service dental practice and is fully out-of-network with all dental insurance plans.**

I understand that this decision allows our practice to focus directly on providing the highest quality of care for our patients without being restricted by the limitations, reimbursement rates, or requirements of individual dental insurance plans.

I understand that **payment for services is due in full at the time services are rendered.** As a courtesy, Phillippi Dental will submit my dental insurance claim on my behalf. I understand that my insurance company will process the claim according to my plan's **out-of-network benefits**, and any reimbursement will be sent directly to me, the patient/policy holder, by my insurance company.

I understand that my dental insurance plan is a contract between myself and my insurance company, and that Phillippi Dental does not guarantee the amount of reimbursement I may receive. I am responsible for understanding my insurance benefits and for any balance not covered or reimbursed by my insurance company.

## Cancellation & Rescheduling Policy

I understand that Phillippi Dental requires 48 hours' notice prior to cancelling or rescheduling my appointment. If I fail to provide 48 hours' notice or fail to come to my scheduled appointment, a $100 fee may apply.

As a courtesy, our office will send an email and/or text appointment reminder prior to my scheduled appointment. I understand that it is my responsibility to notify the office within the required timeframe if I need to cancel or reschedule.

## ACKNOWLEDGMENT & SIGNATURE

Patient / Responsible Party First & Last Name: _____

**Signature: _____** **Date: _____/_____/_____**

If signing on behalf of the patient, please provide your relationship to the patient: _____

# General Information & Office Policies

## To Our Patients

At **Phillippi Dental**, our goal is to provide every patient with exceptional, personalized dental care in a safe, respectful, and comfortable environment. We are committed to maintaining the highest standards of clinical care, patient safety, privacy, and communication.

## MEDICAL & MEDICATION INFORMATION

For your safety, it is important that we have an accurate and current medical history. Please inform our office of **all medications, supplements, allergies, medical conditions, surgeries, and changes in your health**.

Please notify us before treatment if there have been any changes to your health or medications since your last visit.

## STERILIZATION & PATIENT SAFETY

Patient safety is one of our highest priorities. Our office follows established infection-control and sterilization procedures for dental instruments and equipment. Instruments requiring sterilization are properly cleaned, packaged, sterilized, and handled according to applicable infection-control standards.

We are committed to maintaining a clean and safe environment for our patients and team.

## CONSENT TO TREATMENT

I understand that dental treatment will be discussed with me before it is provided. I have the opportunity to ask questions and discuss alternatives. I understand that no specific outcome can be guaranteed and that treatment recommendations may change based on clinical findings.

By signing below, I acknowledge that I have read and understand the General Information & Office Policies of **Phillippi Dental**. I understand the importance of providing accurate medical, medication, and contact information and acknowledge the practice's commitment to my privacy, safety, and high-quality dental care.

**Patient First & Last Name: _____**

**Patient / Responsible Party Signature: _____**

**Date: _____**

**Relationship to Patient (if applicable): _____**

*Thank you for trusting Phillippi Dental with your smile and your care.*