

Phillips & Phillips Dental Associates, P.C.

Please Update Your Information

Please let the front desk know if there has been a change in your **INSURANCE** or **EMPLOYER**. Thank you.

Name (Mr. Mrs. Ms. Dr. Rev.) _____ Date _____

Home Address _____

City _____ State _____ Zip _____ E-Mail-Address _____

Home Phone _____ Work# _____ Ext _____ Cell# _____

Birth date _____

MEDICAL UPDATE

Are you under a physician's care now? Yes No If yes, please explain: _____

Have you ever been hospitalized or had a major operation? Yes No If yes, please explain: _____

Have you ever had a serious head or neck injury? Yes No If yes, please explain: _____

Are you taking any medications, pills, or drugs? Yes No If yes, please explain: _____

Do you take, or have you taken, Phen-Fen or Redux? Yes No

Are you on a special diet? Yes No

Do you use tobacco? Yes No

Do you use controlled substances? Yes No

Do you have osteoporosis or other bone condition? Yes No

Women: Are you:
 Pregnant/Trying to get pregnant? Yes No
 Nursing? Yes No
 Taking oral contraceptives? Yes No

Are you **ALLERGIC** to any of the following? (Please Circle)

Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics

Other Allergies & Explanations: _____

Do you have, or have a recent history of, any of the following? (Please Circle)

AIDS/HIV Positive	Chest Pains	Frequent Headaches	Irregular Heartbeat	Scarlet Fever
Alzheimer's Disease	Cold Sores/Fever Blisters	Genital Herpes	Kidney Problems	Shingles
Anaphylaxis	Congenital Heart Disorder	Glaucoma	Leukemia	Sickle Cell Disease
Anemia	Convulsions	Hay Fever	Liver Disease	Sinus Trouble
Angina	Cortisone Medicine	Heart Attack/Failure	Low Blood Pressure	Spina Bifida
Arthritis/Gout	Diabetes	Heart Murmur	Lung Disease	Stomach/Intestinal Disease
Artificial Heart Valve	Drug Addiction	Heart Pace Maker	Mitral Valve Prolapse	Stroke
Artificial Joint	Easily Winded	Heart Trouble/Disease	Pain in Jaw Joints	Swelling of Limbs
Asthma	Emphysema	Hemophilia	Parathyroid Disease	Thyroid Disease
Blood Disease	Epilepsy or Seizures	Hepatitis A	Psychiatric Care	Tonsillitis
Blood Transfusion	Excessive Bleeding	Hepatitis B or C	Radiation Treatments	Tuberculosis
Breathing Problem	Excessive Thirst	Herpes	Recent Weight Loss	Tumors or Growths
Bruise Easily	Fainting Spells/Dizziness	High Blood Pressure	Renal Dialysis	Ulcers
Cancer	Frequent Cough	Hives or Rash	Rheumatic Fever	Venereal Disease
Chemotherapy	Frequent Diarrhea	Hypoglycemia	Rheumatism	Yellow Jaundice

Have you ever taken any of the **bisphosphonates**, such as **Boniva, Areida, Fosamax, Bondronat, Actonel** or **Zometa**? Yes No

- To the best of my knowledge, all of the preceding answers are true, complete, and correct. I hereby authorize Dr. Phillips to take necessary radiographs(X-rays), study models, photographs, and any other diagnostic aids deemed appropriate to make a thorough diagnosis of the patient's dental needs. I also authorize him to perform treatment, therapy or medication deemed necessary by the doctor and agreed upon by the patient. I understand that the use of anesthetic agents or nitrous oxide gas embodies a certain risk.
- I also understand that responsibility for payment for dental services provided for myself and my dependents is mine and is due and payable at the time services are rendered. There may be additional charges for late payments, broken appointments, returned checks and collection costs.
- I understand that it is necessary to give **24 hours** prior notice to change or cancel any dental appointment in order to avoid charges or fees for a broken appointment. For appointments of 2 or more hours please give a 48 hour notice.
- INSURANCE:** I understand that any insurance estimates given to me by Dr. Phillips' office are estimates and cannot be a guarantee of payment by my insurance company. I understand that I am responsible for the entire balance. I give Dr. Phillips permission to give my insurance company any information that is necessary to process my insurance claim.

Patient or Responsible Party: _____ Date: _____

Doctor Reviewed _____