A SMILE BY DESIGN

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NEW PATIENT INFORMATION

CHILD PATIENT

Name: _____
Last ***First***

Nickname: _____ ***Male*** ***Female***

Birth date: _____/_____/_____ ***Age:*** _____

Home Address: _____

City, State, Zip: _____

Home Phone: _____

School _____ ***Grade:*** _____

List any musical instruments played: _____

Hobbies: _____

Sports: _____

Who is accompanying patient today? _____
Name & Relationship

List brothers/sisters with birthdates _____

General Dentist: _____ ***Last visit date:*** _____

Whom may we thank for referring you? _____

Parent Information

Mother's Name: _____ ***Father's Name:*** _____

Work Phone: _____ ***Ext.***_____ ***Work Phone:*** _____ ***Ext.***_____

Employer: _____ ***Employer:*** _____

Occupation: _____ ***Occupation:*** _____

Email: _____

Person Responsible for Account

Name: _____

Billing Address: _____

Home Phone: _____ ***Cell:*** _____

Employer: _____ ***Work Phone:*** _____

SS No. _____

(Continue to page 2)

Medical History

Please check if the patient has or has had any of the following:

☐ *Heart trouble*
☐ *Heart murmur/heart defect*
☐ *Artificial valves/pacemaker*
___ *Rheumatic fever*
___ *HIV+ / AIDS*
___ *Hepatitis*
___ *Tuberculosis*
___ *Abnormal bleeding*
___ *Diabetes*
___ *Thyroid problems*
___ *Kidney or liver problems*
___ *Asthma/difficulty breathing*
___ *Bone/joint disorders*
__ *Osteoporosis or Bisphosphonate use*
__ *Emotional problems*
__ *Epilepsy/seizures*
__ *Neurologic problems*
__ *Sinus problems*
__ *Tonsils/adenoids removed*
__ *Cancer*
__*Use of cigarettes, cigars or smokeless tobacco*
__*Severe/frequent headaches*
__ *Birth defects*
__*Adopted*

Is the Patient currently under the care of a physician? _____
Physician's name: _____
List drugs or medications now being taken: _____
List any serious illnesses or operations: _____
List any allergies: _____

Dental History

Please check box if the patient has or has had any of the following:

__*Any injuries to face, mouth or teeth*
__*Thumb/ finger sucking*
__*Mouth breather*
__*Any missing permanent teeth*
__*Any extra permanent teeth*
__*Teeth removed by extraction*
__*Tongue thrusting problem*
__*Speech problems*
__*Jaw joint problems*
__*Clenching or grinding teeth*
__*Bleeding gums/gum recession*

Does patient brush his/her teeth daily? Yes No
Does patient floss his/her teeth daily? Yes No

What would you like to have orthodontic treatment accomplish? _____
_____

Has an orthodontist been consulted previously? _____
Reason: _____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in my medical status.

I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

Signature ***Date***