B. ERIC PHILLIPS D.M.D., P.A.
ENDODONTICS AND ENDODONTIC MICROSURGERY

Patient Information

Last Name _____ First _____ Middle _____

What do you prefer to be called in our office _____ Male Female (circle one)

Date of Birth _____ Social Security # _____

Address_____ City _____State _____ Zip _____

Home # _____ Alternate # _____cell/office (circle one)

OK to leave message Yes No (circle one) email _____

Employer _____ Phone _____

Employer address _____ Occupation _____

Referring Dentist _____

How long have you been a patient in their office? _____

Spouse/Parent or Guardian

Last Name _____ First _____ Middle _____

Address_____ City _____State _____ Zip _____

Home # _____ Alternate #_____cell/office (circle one)

OK to leave message Yes No (circle one) email _____

Employer _____ Phone _____

Emergency Contact (if different) _____ Phone _____

Insurance Information

Primary Dental Insurance _____ Secondary Dental Insurance _____

Employee Name _____ Employee Name _____

Employee SS# _____ Employee SS# _____

Date of Birth _____ Date of Birth _____

Employer _____ Employer _____

Insurance Address _____ Insurance Address _____

Insurance Phone _____ Insurance Phone _____

Group Policy # _____ Group Policy # _____

MEDICAL HISTORY

Physician's Name _____ Date of Last Visit _____

	Yes	No
1. Are you currently under medical treatment?	☐	☐
2. Have you ever had any serious illnesses or operations?	☐	☐
3. Are you currently taking any medication? ..	☐	☐
Please list: _____		
_____		
_____		
_____		
4. Are you currently, or have you ever taken a Bisphosphonate class of medication (eg: Zometa, Aredia Fosamax, Boniva, Actonol).	☐	☐
5. Do you smoke?	☐	☐
6. Do you use alcohol, cocaine or other drugs?	☐	☐
7. Do you need to take prophylactic antibiotics for any health reason?	☐	☐

8. Are you allergic to any of the following:

	Yes	No
Latex	☐	☐
Local Anesthetics (eg. Novocaine)	☐	☐
Penicillin or other Antibiotic	☐	☐
Sulfa Drugs	☐	☐
Barbiturates (sleeping pills)	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Other	☐	☐

9. (Women Only) Are You:

Pregnant?	☐	☐
Nursing?	☐	☐
Taking birth control pills?	☐	☐

Please check all that apply:

AIDS ☐	Emphysema ☐	Pacemaker ☐
Anemia ☐	Epilepsy ☐	Psychiatric Care ☐
Arthritis, Rheumatism ☐	Fainting or Dizziness ☐	Radiation Treatment ☐
Artificial Heart Valves ☐	Glaucoma ☐	Respiratory Disease ☐
Artificial Joints ☐	Headaches ☐	Rheumatic Fever ☐
Asthma ☐	Heart Murmur ☐	Scarlet Fever ☐
Back Problems ☐	Heart Problems ☐	Shortness of Breath ☐
Bleeding abnormally ☐	Heart Valvular Disease ☐	Sinus Trouble
Blood Disease ☐	Hepatitis –Type_____ ☐	Stroke ☐
Cancer ☐	High Blood Pressure ☐	Swelling of Feet/Ankles ☐
Chemical Dependency ☐	HIV Positive ☐	Swollen Neck Glands ☐
Chemotherapy ☐	Jaundice ☐	Thyroid Problems ☐
Chronic Fatigue Syndrome ☐	Jaw Pain ☐	Tonsillitis ☐
Circulatory Problems ☐	Kidney Disease ☐	Tuberculosis ☐
Congenital Heart Lesions ☐	Liver Disease ☐	Tumor/growth on head/neck ☐
Cortisone Treatments ☐	Low Blood Pressure ☐	Ulcer ☐
Cough-persistent or bloody ☐	Mitral Value Prolapse ☐	Venereal Disease ☐
Diabetes ☐	Nervous Problems ☐	

Please Read and Sign

The above medical history is accurate to the best of my knowledge. I, the undersigned, consent to the performing of any procedure necessary to evaluate, diagnose, and treat my condition. I authorize and request the administration of such drugs and/or anesthetics as may be deemed advisable by the dentist.

I authorize the above doctor and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits and agree that my insurance carrier will pay the provider directly. The agree that the below signature will be noted as my "signature on file" for the purpose of electronic claims filing.

I also acknowledge I have received a copy of this office's Notice of Privacy Practices.

Signature or Responsible Party _____ Date _____