Phillip S. Tully III, DMD, PC
Dr. Phillip Tully III and Dr. W. Newton Sharp
7270 North Lake Drive, Suite 100
Columbus, GA 31909

Patient Information

Patient's Name _____ Preferred Name _____
Address_____
City _____ State _____ Zip _____
Home Telephone Number (___)_____ E-Mail Address _____
Birthdate ___/___/_____
Employer _____
Occupation _____
Work Telephone Number (___)_____ Cell Phone Number (___)_____
Social Security Number _____
How Did You Hear About Our Office? _____
_____

Spouse's Information

Name _____ Birthday ___/___/_____
Employer _____
Occupation _____
Work Telephone Number (___)_____ Cell Phone Number (___)_____
Social Security Number _____

Closest Relative Not Living With You _____
Relationship _____
Address _____
Telephone Number (___) _____

Insurance Information

Do You Have Dental Insurance? Yes No If yes, please complete the following:

Assignment & Release: I authorize the dentist to release any information requested by my insurance company. I hereby assign my insurance directly to Phillip S. Tully III DMD, PC. I understand that I am financially responsible for all non-covered services and any services not paid by my insurance company within 14 days.

Signature of Patient _____ Date _____

PRIMARY INSURANCE
Insured's Name _____ Identification No _____
Insured's Employer _____ Group Number _____
Insurance Company _____ Ins Co Phone No _____
Insurance Company Address _____

SECONDARY INSURANCE
Insured's Name _____ Identification No _____
Insured's Employer _____ Group Number _____
Insurance Company _____ Ins Co Phone No _____
Insurance Company Address _____

PATIENT MEDICAL HISTORY Physician's Name: _____

1. Are you under the care of a physician? Yes No
   If so, what is the condition being treated?
   _____
   My last physical exam was on _____
   Are you or could you be pregnant? Yes No
2. Have you been hospitalized or had any surgeries within the last five years? Yes No
   If so, what was the problem?
   _____
   _____
   _____
   _____
3. Are you taking any medications? Yes No
   (Prescription or any over the counter)
   If so, what?
   _____
   _____
   _____
   _____
   _____
   _____
   _____
   _____
   Are you taking any blood thinners? Yes No
   If so, what? _____
   Are you or have you ever taken Phen/Fen or Redux? Yes No
4. Do you have or have you had any of the following diseases or problems?
   a. Cancer (Type: _____) Yes No
   b. Diabetes (controlled by insulin, diet) Yes No
   c. Epilepsy or seizures Yes No
   d. Jaundice or liver disease Yes No
   e. Hepatitis (Type: _____) Yes No
   f. Tuberculosis (Active or Passive) Yes No
      Date Treatment Completed _____
   g. Venereal Disease (bad blood) Yes No
   h. HIV positive Yes No
   i. Fibromyalgia Yes No
   j. Rheumatic heart disease Yes No
   k. Congenital heart lesions or murmur Yes No
   l. Mitral valve prolapse Yes No
   m. High blood pressure Yes No
   n. Lupus Yes No
   o. Rheumatoid Arthritis Yes No
   p. Thyroid Yes No
   q. Cardiovascular disease (heart) trouble, heart attack, coronary insufficiency, coronary occlusion) Yes No
   r. Do you have a pacemaker? (If so, when _____) Yes No
   s. Any other disease/problem not listed? _____ Yes No
5. Have you had any cardiac surgery? Yes No
   If so, what type _____
   When? _____
6. Have you had any abnormal bleeding associated with previous extractions, surgery or trauma? Yes No
7. Have you had a prosthetic joint replacement? (hip, knee, etc.) If so, when? _____ Yes No
8. Are you allergic to or have you reacted adversely to:
   a. Local Anesthetics Yes No
   b. Penicillin Yes No
   c. Other Antibiotics Yes No
      _____
   d. Sulfa Drugs Yes No
   e. Aspirin Yes No
   f. Codeine Yes No
   g. Iodine Yes No
   h. Latex Yes No
   i. Other (If so, what _____) Yes No
9. Do you use tobacco products? Yes No
   If yes, what type and how often? _____
   _____
9. Do you have any medical conditions that would prohibit you from receiving any dental treatment? Yes No
   If so, what? _____

CONSENT: To the best of my knowledge, the above medical history is correct. I hereby authorize doctor or designated staff to take x-rays, study models, photographs and other diagnostic aids deemed appropriate to make a thorough diagnosis. Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care. I am financially responsible for all services.

Permission **is/is not** (please circle one) given for photography (close up pictures of patient's mouth only, which does not show his/her face, no reveal identity) for publicity purposes.

Signature of Patient _____ Date _____