TIPPETS DENTISTRY

Patient Information

Patient Name: _____ Date: _____ Gender____
Last, First MI (Preferred Name)

Social Security #: _____ Birth Date: _____Email:_____

Phone (Home): _____ (Work): _____ (Cell):_____

We may do courtesy phone calls by email or text. Are you able to receive text on your cell phone? Y N

Whom may we thank for referring you to our practice: _____

Address:_____
Street Apartment #

_____
City State Zip Code

Health Information

Date of Last Dental Visit: _____ Reason for this visit: _____

Have you ever had any of the following? Please check those that apply:

☐	AIDS/ HIV +	☐	Breathing Problems	☐	Hay Fever	☐	Recent Weight Loss
☐	Alzheimer Disease	☐	Bruise Easily	☐	Heart Attack/Failure	☐	Renal Dialysis
☐	Anaphylaxis	☐	Cancer	☐	Heart Disease	☐	Rheumatic Fever
	ALLERGIES:	☐	Chemotherapy	☐	Heart Murmur	☐	Rheumatism
	☐ Sulfa	☐	Chest Pains	☐	Hemophilia	☐	Scarlet Fever
	☐ Codeine	☐	Congenital Heart Disease	☐	Hepatitis – A B C	☐	Shingles
	☐ Aspirin	☐	Convulsions	☐	High Blood Pressure	☐	Sickle Cell Disease
	☐ Metal	☐	Cortisone Medication	☐	Herpes	☐	Sinus Problems
	☐ Acrylic	☐	Cold Sores	☐	Hives or Rash	☐	Spina Bifida
	☐ Penicillin	☐	Diabetes	☐	Hypoglycemia	☐	Stomach Problems
	☐ Latex	☐	Drug/Alcohol Addiction	☐	Kidney Disease	☐	Stroke
	☐ Other_____	☐	Emphysema	☐	Leukemia	☐	Swelling of Limbs
☐	Anemia	☐	Epilepsy or Seizures	☐	Liver Disease	☐	Thyroid Problems
☐	Angina	☐	Excessive Bleeding	☐	Low Blood Pressure	☐	Tonsilitis
☐	Arthritis/Gout	☐	Excessive Thirst	☐	Lung Disease	☐	TMJ Problems
☐	Artificial Joints	☐	Fainting	☐	Mitral Valve Prolapse	☐	Tuberculosis
☐	Artificial ☐ Valve	☐	Frequent Cough	☐	Pacemaker	☐	Tumors
☐	Asthma	☐	Frequent Diarrhea	☐	Parathyroid Disease	☐	Ulcers
☐	Blood Disease	☐	Genital Herpes	☐	Psychiatric Care	☐	Venereal Disease
☐	Blood Transfusion	☐	Glaucoma	☐	Radiation Treatment	☐	Yellow Jaundice

Please list all medication you are currently taking: _____

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain:_____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain:_____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain:_____
- Name of Physician: _____ Phone:_____
- Are you currently taking Coumadin, or other blood thinning medication? ☐ Yes ☐ No
- Women only: Are you pregnant? ☐ Yes ☐ No Due date? _____ Birth control? ☐ Yes ☐ No
  Nursing? ☐ Yes ☐ No
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain:_____

DENTAL HISTORY

***Do you have or have you had any of the following*:**

☐	Bad Breath	☐	Sensitivity When Biting	☐	Sensitive to Temperature	☐	Grinding Teeth
☐	Bleeding Gums	☐	Fillings-Loose or Broken	☐	Sensitive to Sweets	☐	Sores In Mouth
☐	Clicking or Popping Jaw	☐	Periodontal Treatment	☐	Clenching Teeth	☐	Whitening

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____

Street

_____

City State Zip

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No

Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____

Street City State

Zip Code

Insured's Employer Name:_____ Insurance Co Phone #:_____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address:_____

_____

Consent for Services

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail. I understand the above information is necessary to provide me with dental care in a safe and efficient manner.

The undersigned hereby authorizes Dr. Tippets and his staff to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the patient's dental needs.

I authorize and hereby grant Tippets Dentistry the release of any photographs or pictures taken to be used on and to any of their assigns, the absolute and irrevocable right and permission, with respect to the photographs taken of me, or in which I may be included with others; to use, re-use, and/or publish the same in whole or in part, individually, or in conjunction with other photographs, without limitation in perpetuity.

I authorize and give consent to dental services between doctor and patient and/or parent or guardian to be necessary or advisable; including the use of local anesthesia and other medication as indicated. I certify to the above statements regarding any medical condition.

I authorize the dentist to release any information including the diagnosis and records or treatment or examination for myself and my dependent(s) to third party insurance carriers, payers, and/or healthcare practitioners. I authorize the payment from my insurance carrier to submit payment directly to the dentist or dental practice to be applied directly to any outstanding balance on my account.

I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance, and I may be billed for this remaining balance. I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependents (if any).

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

_____ __ Date:_____

Signature of Patient, Parent of Guardian

_____ Date:_____

Responsible Party