WELCOME

DATE _____

HAS ANYONE IN YOUR FAMILY BEEN TO OUR OFFICE BEFORE?
YES OR NO (PLEASE CIRCLE)
IF YES PLEASE LIST NAME _____

(PLEASE PRINT)
NAME_____ HOME#_____
FIRST MIDDLE LAST

ADDRESS_____APT____ WORK#_____

CITY_____STATE_____ZIP_____BIRTHDATE_____

SEX M/F (CIRCLE ONE) MR. MRS. MS. (CIRCLE ONE)DL#_____ SS#_____

EMPLOYER_____

ADDRESS_____SUITE#____CITY_____STATE_____ ZIP_____

E-MAIL ADDRESS_____ FAX #_____ CELL # _____

(SPOUSE/PARENT INFORMTION MAY BE NEEDED FOR INSURANCE PURPOSES SO PLEASE COMPLETE)

SPOUSE (OR PARENT)_____ HOME# _____

ADDRESS_____APT____ WORK#_____

CITY_____STATE_____ZIP_____ BIRTHDATE_____

SEX M / F (CIRCLE ONE) MR. MRS. MS. (CIRCLE ONE)DL#_____ SS#_____

EMPLOYER_____

ADDRESS_____ SUITE #____CITY_____STATE_____ ZIP_____

E-MAIL ADDRESS_____ FAX #_____ CELL#_____

WHOM MAY WE THANK FOR REFERRING YOU? _____

WHAT ARE YOUR HOBBIES OR INTERESTS?_____

PLEASE ADD ANYTHING YOU FEEL IMPORTANT FOR THE DOCTOR TO KNOW_____

ARE YOU COVERED BY INSURANCE &/OR A DISCOUNT PLAN? YES/NO (CIRCLE ONE…IF YES PLEASE PROVIDE YOUR INSURANCE CARD)

ARE YOU A FULL-TIME COLLEGE STUDENT? YES/NO (CIRCLE ONE…IF YES, WE MUST HAVE A COPY OF THE CURRENT SEMESTERS REGISTRATION FORM SHOWING PROOF OF PAYMENT TO YOUR COLLEGE. WITHOUT THIS INFORMATION WE CANNOT FILE DENTAL INSURANCE ON YOUR BEHALF.)

HEALTH HISTORY

PATIENT NAME_____
Last First Initial Date of Birth

Physician's Name_____
Address_____
_____

Do you have or have you had (please check those that apply):

- ☐ Abnormal Bleeding
- ☐ AIDS
- ☐ Alcohol Dependency
- ☐ Anemia
- ☐ Arthritis or Rheumatism
- ☐ Artificial Heart Valve
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Back Problems
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Congenital Heart Lesion
- ☐ Cortisone Treatments
- ☐ Diabetes
- ☐ Drug Dependency
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fainting or dizziness
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Hepatitis
  Type_____
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ HIV Positive
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Nervous Problems
- ☐ Pacemaker
- ☐ Persistent Cough
- ☐ Psychiatric Treatment
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Shortness of Breath
- ☐ Sinus Trouble
- ☐ Skin Rash
- ☐ Stomach Ulcer
- ☐ Stroke
- ☐ Swelling of Feet/Ankles
- ☐ Swollen Neck Gland
- ☐ Thyroid Problems
- ☐ Tobacco Use
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Tumor or growth
- ☐ Unexplained Weight Loss/Gain
- ☐ Venereal Disease

Women:

Are you pregnant?
☐ Yes ☐ No

Due Date_____

Are you nursing?
☐ Yes ☐ No

Medications

List medications you are currently taking: _____
_____
_____
_____

Pharmacy Name:_____

Phone:_____

Allergies

- ☐ Aspirin
- ☐ Codeine
- ☐ Pain Medication
- ☐ Iodine
- ☐ Anesthetics
- ☐ Antibiotics
- ☐ Penicillin
- ☐ Sulfa
- ☐ Latex
- ☐ Other

IN CASE OF EMERGENCY, CONTACT:

Name_____
Relationship_____

Phone
Number_____

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT/GUARDIAN'S SIGNATURE_____ DATE_____

OFFICE POLICIES (PLEASE READ CAREFULLY & SIGN)

FILING OF INSURANCE:

PLEASE BE ADVISED THAT OUR OFFICE DOES NOT GUARANTEE INSURANCE BENEFITS. WE WILL MAKE EVERY ATTEMPT TO VERIFY AND QUOTE YOUR INSURANCE COVERAGE TO YOU ACCURATELY, HOWEVER ANY PORTION DENIED OR UNPAID BY YOUR INSURANCE COMPANY WILL BE YOUR FINANCIAL RESPONSIBILITY.

IF YOUR INSURANCE COVERAGE HAS CHANGED AND OUR OFFICE HAS NOT BEEN ADVISED BY YOU UNTIL THE TIME OF YOUR APPOINTMENT THEN YOU MAY BE REQUIRED TO PAY FOR YOUR SERVICES AT THAT TIME AND SEEK REIMBURSEMENT DIRECTLY FROM YOUR INSURANCE COMPANY.

IN THE EVENT THAT YOU ARE REFERRED TO A DENTAL SPECIALIST, PLEASE BE AWARE THAT WE DO NOT HAVE ACCESS TO YOUR INSURANCE COMPANIES PROVIDER LISTING, THEREFORE YOU MAY NEED TO CONTACT YOUR INSURANCE PRIOR TO AN APPOINTMENT WITH A SPECIALIST.

PLEASE REMEMBER THAT YOUR INSURANCE IS A CONTRACT BETWEEN YOU, YOUR EMPLOYER AND YOUR INSURANCE COMPANY. WE ARE STRICTLY A THIRD-PARTY THAT WILL TAKE ASSIGNMENT OF ESTIMATED BENEFITS. INSURANCE IS BILLED AS A COURTESY TO THE PATIENTS FOR TIPPIT DENTAL GROUP. PLEASE SIGN BELOW THAT YOU HAVE READ AND UNDERSTAND THAT "EXPECTED INSURANCE PAYMENT" IS ONLY AN ESTIMATE AND NOT A GUARANTEE OF PAYMENT. AS THE PATIENT/INSURED YOU AGREE TO BE RESPONSIBLE FOR ANY AMOUNT NOT PAID FOR BY YOUR INSURANCE COMPANY FOR ANY REASON.

_____

Signature ***Date***

SIGNATURE ON FILE FOR INSURANCE FILING

I authorize use of this form on all of my insurance submissions.
I authorize release of information to all of my Insurance Companies.
I understand that I am responsible for my bill in the event my insurance company does not pay.
I authorize my doctor to act as my agent in helping me obtain payment from my Insurance Companies.
I authorize payment directly to my doctor.
I permit a copy of this authorization to be used in place of the original.

PLEASE SIGN BELOW THAT YOU HAVE READ AND UNDERSTAND THE "SIGNATURE ON FILE" REQUIREMENTS FOR FILING YOUR INSURANCE.

_____

Signature ***Date***

ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES

I, (PLEASE PRINT)_____, have read &/or received a copy of this office's Notice of Privacy Practices.

If you would a copy of our

_____

Signature Date

BELOW FOR OFFICE USE ONLY:

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

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