(PLEASE PRINT)

## Patient Information

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

E-mail _____

City _____

State _____ Zip _____

Sex ☐ M ☐ F Age _____

Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Patient Employer/School _____

Occupation _____

Employer/School Address _____

_____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

## Dental Insurance

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

**ASSIGNMENT AND RELEASE**

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to
Name of Insurance Company(ies)

Dr. DR. ADAM D. CLOCK all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____
Date Relationship to Patient

## Phone Numbers

Home (_____) _____ Work (_____) _____ Ext _____ Alt. Phone (_____) _____

Spouse's Work (_____) _____ Best time and place to reach you _____

**IN CASE OF EMERGENCY, CONTACT** (Specify someone who does not live in your household.)

Name _____ Relationship _____

Phone (_____) _____ Alt. Phone (_____) _____

## Dental History

Reason for today's visit _____

_____

Former Dentist _____

City/State _____

Date of last dental visit _____

Date of last dental X-rays _____

Place a mark on "yes" or "no" to indicate if you have had any of the following:

| | | |
|---|---|---|
| Bad breath | ☐ Yes | ☐ No |
| Bleeding gums | ☐ Yes | ☐ No |
| Blisters on lips or mouth | ☐ Yes | ☐ No |
| Burning sensation on tongue | ☐ Yes | ☐ No |
| Chew on one side of mouth | ☐ Yes | ☐ No |
| Cigarette, pipe, or cigar smoking | ☐ Yes | ☐ No |
| Clicking or popping jaw | ☐ Yes | ☐ No |
| Dry mouth | ☐ Yes | ☐ No |
| Fingernail biting | ☐ Yes | ☐ No |
| Food collection between the teeth | ☐ Yes | ☐ No |
| Foreign objects | ☐ Yes | ☐ No |
| Grinding teeth | ☐ Yes | ☐ No |
| Gums swollen or tender | ☐ Yes | ☐ No |
| Jaw pain or tiredness | ☐ Yes | ☐ No |
| Lip or cheek biting | ☐ Yes | ☐ No |
| Loose teeth or broken fillings | ☐ Yes | ☐ No |
| Mouth breathing | ☐ Yes | ☐ No |
| Mouth pain, brushing | ☐ Yes | ☐ No |
| Orthodontic treatment | ☐ Yes | ☐ No |
| Pain around ear | ☐ Yes | ☐ No |
| Periodontal treatment | ☐ Yes | ☐ No |
| Sensitivity to cold | ☐ Yes | ☐ No |
| Sensitivity to heat | ☐ Yes | ☐ No |
| Sensitivity to sweets | ☐ Yes | ☐ No |
| Sensitivity when biting | ☐ Yes | ☐ No |
| Sores or growths in your mouth | ☐ Yes | ☐ No |

How often do you floss? _____

How often do you brush? _____

# Dental Registration and History


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## Health History

Physician's Name _____ Date of last visit _____

Have you ever used a bisphosphonate medication? Common brand names are Fosamax, Actonel, Atelvia, Didronel, Boniva. ☐ Yes ☐ No

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ☐ Yes ☐ No

Place a mark on "yes" or "no" to indicate if you have had any of the following:

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| AIDS/HIV | ☐ Yes ☐ No | Epilepsy | ☐ Yes ☐ No | Respiratory Disease | ☐ Yes ☐ No |
| Anemia | ☐ Yes ☐ No | Fainting or dizziness | ☐ Yes ☐ No | Rheumatic Fever | ☐ Yes ☐ No |
| Arthritis, Rheumatism | ☐ Yes ☐ No | Glaucoma | ☐ Yes ☐ No | Scarlet Fever | ☐ Yes ☐ No |
| Artificial Heart Valves | ☐ Yes ☐ No | Headaches | ☐ Yes ☐ No | Shortness of Breath | ☐ Yes ☐ No |
| Artificial Joints | ☐ Yes ☐ No | Heart Murmur | ☐ Yes ☐ No | Sinus Trouble | ☐ Yes ☐ No |
| Asthma | ☐ Yes ☐ No | Heart Problems | ☐ Yes ☐ No | Skin Rash | ☐ Yes ☐ No |
| Back Problems | ☐ Yes ☐ No | Hepatitis Type _____ | ☐ Yes ☐ No | Special Diet | ☐ Yes ☐ No |
| Bleeding abnormally, with | | Herpes | ☐ Yes ☐ No | Stroke | ☐ Yes ☐ No |
| extractions or surgery | ☐ Yes ☐ No | High Blood Pressure | ☐ Yes ☐ No | Swollen Feet or Ankles | ☐ Yes ☐ No |
| Blood Disease | ☐ Yes ☐ No | Jaundice | ☐ Yes ☐ No | Swollen Neck Glands | ☐ Yes ☐ No |
| Cancer | ☐ Yes ☐ No | Jaw Pain | ☐ Yes ☐ No | Thyroid Problems | ☐ Yes ☐ No |
| Chemical Dependency | ☐ Yes ☐ No | Kidney Disease | ☐ Yes ☐ No | Tonsillitis | ☐ Yes ☐ No |
| Chemotherapy | ☐ Yes ☐ No | Liver Disease | ☐ Yes ☐ No | Tuberculosis | ☐ Yes ☐ No |
| Circulatory Problems | ☐ Yes ☐ No | Low Blood Pressure | ☐ Yes ☐ No | Tumor or growth on head | |
| Congenital Heart Lesions | ☐ Yes ☐ No | Mitral Valve Prolapse | ☐ Yes ☐ No | or neck | ☐ Yes ☐ No |
| Cortisone Treatments | ☐ Yes ☐ No | Nervous Problems | ☐ Yes ☐ No | Ulcer | ☐ Yes ☐ No |
| Cough, persistent or bloody | ☐ Yes ☐ No | Pacemaker | ☐ Yes ☐ No | Venereal Disease | ☐ Yes ☐ No |
| Diabetes | ☐ Yes ☐ No | Psychiatric Care | ☐ Yes ☐ No | Weight Loss, unexplained | ☐ Yes ☐ No |
| Emphysema | ☐ Yes ☐ No | Radiation Treatment | ☐ Yes ☐ No | | |
| Do you wear contact lenses? | ☐ Yes ☐ No | | | | |

**Women:**

Are you pregnant? ☐ Yes ☐ No Due date _____ Are you nursing? ☐ Yes ☐ No

Taking birth control pills? ☐ Yes ☐ No

## Medications

List any medications you are currently taking and the correlating diagnosis:

_____

_____

Pharmacy Name _____

Phone (_____) _____

## Allergies

| | |
|---|---|
| ☐ Aspirin | ☐ Local Anesthetic |
| ☐ Barbiturates (Sleeping pills) | ☐ Penicillin |
| ☐ Codeine | ☐ Sulfa |
| ☐ Iodine | ☐ Other _____ |
| ☐ Latex | _____ |

## Updates (To be filled in at future appointments)

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions? _____

Are you taking any new medications? _____ If so, what? _____

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions? _____

Are you taking any new medications? _____ If so, what? _____

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

Tiptonpark
DENTISTRY

# WRITTEN FINANCIAL POLICY

**Payment Options Include:** Cash, Check, Visa, MasterCard, Discover, American Express, Debit Cards, Health Savings Account (HSA), Flex Spending (FSA), CareCredit (pre-approval required), and in-house payment plans (pre-approval required)
**Payment (including copays, deductibles and previous account balances) is due on the day of service.**

**Insurance Benefits/Estimates** - Tipton Park Dentistry is an independent and unrestricted dental provider, which means we offer you high-quality service, high-quality materials and high-quality technology. We are able to do this by not contracting with outside, 3rd party dental plans. We are able to file and accept payment from most insurances, with very few exceptions! To do so, you must provide us with accurate and up-to-date insurance information and a copy of your insurance cards.

We work with Guardian, Aetna, Cigna, Anthem, Humana, MetLife, Delta, Kroot, Physicians Mutual, Reliance Standard, Dunn, Principal, United, SunLife, Best Life, Paramount and countless others on a daily basis. Dental plans differ significantly. Each patient should know and understand his or her individual benefit package, including frequency limitations, before seeking care. Please contact your insurance company directly if you have questions regarding your coverage.

We try our best to provide accurate estimates for treatment. However, benefits and coverage vary significantly from plan to plan and change frequently. Many plans have specific exclusions and do not cover all procedures. Most policies cover what they consider a "usual and customary fee." Our fees generally, but not always, fall within the usual and customary fee structure. During treatment, should the need for additional treatment arise, the fees/estimate could change.

**Insurance Payments** - We will provide timely information and cooperate with the regulations and requests of your insurance company to assist in the claim being paid. Our office will not, however, enter into a dispute with your insurance company over any claim. We expect final payment from your insurance company **within 60 days of treatment**. If payment is not received from insurance, if your insurance company pays less than expected, or if your claim is denied, you will be responsible for paying the remaining, unpaid balance at that time. After 60 days, the entire balance, becomes your responsibility.

**Overdue Balances** - If your account has an unpaid balance, we will do our best to remind you with statements, phone calls, emails and/or texts. Any unpaid balance over 90 days is considered delinquent and will be turned over to Allied Collection Service. We reserve the right to release any necessary information required to collect for services rendered. By signing below, you expressly consent and agree to Tipton Park Dentistry and its affiliates, agents and service providers to use written, electronic or verbal means to contact you. This consent includes, but is not limited to, contact by manual methods, prerecorded or artificial voice messages, text messages, emails and/ or automatic telephone dialing systems. Tipton Park

Dentistry and its affiliates, agents and service providers may use any email address or any telephone number you provide, now or in the future, including a number for a cellular phone or other wireless device, regardless of whether you incur charges as a result. You will be responsible for any expenses incurred while trying to collect on your account, including legal fees, collection agency fees, and interest charges.

**Missed Appointments** - We strive to keep wait times short and provide open access to our providers. **When we reserve an appointment time for you, we will be here.** We understand that missing an appointment or last-minute rescheduling is sometimes unavoidable. If you will be delayed or unable to keep a reserved appointment, please call us as soon as possible to give the appointment time to another patient. If your family misses multiple appointments, you will be placed on a Same Day Only list. If additional appointments are missed, you may be dismissed from the practice.

**Minors** - Please plan to be present at appointments with your child/guard if he or she is under 18. If you cannot be here, please make prior arrangements with our staff. The parent/guardian accompanying the minor child is responsible for payment. Regardless of divorce decree, the parent who brings the minor and has signed the financial agreement is responsible to pay for the minor's services. We are unable to bill separate parties.

**Returned/Insufficient checks** will be charged a $50 fee.

**Refunds** – Refund requests will be determined on a case by case basis. Refunds for overpayment will be processed once all treatment is completed and all insurance payments for the account are received.

**By signing, you agree to the Written Financial Policy terms, authorize the staff to perform treatment and are responsible for the charges related to the treatment.**
We invite you to discuss with us any questions regarding our services.

_____ _____
Patient Name (Printed) Date

_____
Patient, Parent, or Guardian Signature

## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below, I have reviewed this office's Notice of Privacy Practices.
(A take-home copy of this notice is available upon request.)

_____ _____
Patient, Parent, or Guardian Signature Date