Chart#: _____
FOR OFFICE USE ONLY

Patient Information

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

Gender(M/F): ____ Marital Status: _____ Birth Date: _____ Social Security #: _____

Driver's License #: _____ E-Mail Address: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Phone #'s: Home _____ Work _____ Ext _____ Best time to call: _____

FAX _____ Pager _____ Other _____

Referral Information

Name of person, office or other source referring you to our practice:

_____

Spouse or Responsible Party Information

Name: _____ Date: _____
Last First MI (Preferred Name)

Gender(M/F): ____ Marital Status: _____ Birth Date: _____ Social Security #: _____

Driver's License #: _____ E-Mail Address: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Phone #'s: Home _____ Work _____ Ext _____ Best time to call: _____

FAX _____ Pager _____ Other _____

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____

Address: _____
Street City State Zip Code Phone

Insurance Information

Primary

Name of Insured: _____
Last First MI

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

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

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

Insurance Plan Name and Address: _____

_____

Secondary

Name of Insured: _____
Last First MI

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

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

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

Insurance Plan Name and Address: _____

_____

Tippin Dental Group
www.TippinDentalGroup.com
431 Victoria • Newton, KS 67114
appointments@tippindentalgroup.com
(316)283-2970

Patient Name: _____ _____ ___ _____
Last First MI Preferred Name

Date of last dental visit? Treatment you had completed?

_____

_____

Current Medical Conditions (circle all that apply): ADHD; Anemia; Anxiety; Arthritis; Asthma; Autism; Blood Disease; Cancer; Diabetes-Type I or Type II; Dizziness; Fainting; Epilepsy; Fibromyalgia; Head Injuries; Heart Disease; Hepatitis; High Blood Pressure; HIV/AIDS; Kidney Disease; Liver Disease; Mental Disorders; Nervous Disorders; Respiratory Problems; Seasonal Allergies; Sinus Problems; Sleep Apnea; STD's; Stroke; Ulcers
Do you have any other medical conditions not previously recorded? Please explain:

_____

_____

_____

_____

If you are a NEW patient, have you had a Panoramic X-ray in the last 5 years? ○ Yes ○ No

Do you have a latex allergy(Yes/No)? ○ Yes ○ No

Do you agree with the HIPPA Privacy Practices and polices? ○ Yes ○ No

May we contact you at your work number if needed? ○ Yes ○ No

Have you been hospitalized in the last 2 years(Yes/No)? If yes, please explain:

_____

_____

Are you allergic to Penicillin or any other medications? Please list:

_____

_____

Are you taking any kind of blood thinning medications? Please list:

_____

_____

Have you ever taken medication for osteoporosis or cancer treatment(Yes/No)? If yes, please explain:

_____

_____

Do you have any artificial heart valves or joint replacements(Yes/No)(Date of replacement)? If yes, please explain:

_____

_____

Are you currently pregnant? (If yes, please list due date)

_____

_____

If patient is a child/minor: I understand Tippin Dental Group requires the presence of a parent or legal guardian at all appointments?

○ Yes ○ No

Do you currently use Tobacco? Please specify:

_____

_____

Please list any medications you are currently taking, or provide a copy of a list:

_____

_____

_____

_____

_____

_____

Preferred Pharmacy name, address, and phone:

_____

_____

Emergency contact name and phone number:

_____

_____

Signature _____ **Date** _____

Response Date:
____/____/_____