Legacy Dental

40710 California Oaks Rd. Suite B Murrieta, CA 92562
Phone (951)677-5113 Fax (951)508-0311

Thank you for visiting the office of Dr. Tibbitts and Associates. We want your visit to be pleasant and comfortable. Please help us by completing this form.

Patient Information

Name: Last_____ First_____ M.I._____ Nickname_____

Address: Street_____

City _____ State _____ Zip Code _____

DOB: _____ ❒ Male ❒ Female Social Security # _____ DL# _____

Marital Status: ❒ Single ❒ Married ❒ Separated ❒ Divorced ❒ Widowed Patient's Email: _____

Pharmacy Name: _____ Pharmacy Number: _____

Pharmacy Location: _____

Home (___)_____ Work(___)_____ Mobile(___)_____

Emergency Contact Name: _____ Phone:(_____)_____

How would you like to receive appointment reminders?: ❒ Phone Call ❒ Email ❒ Text

Employer: _____ May we contact you at work? ❒ Yes ❒ No

How did you hear about us? _____ If Internet : ❒ Google ❒ Yelp ❒ Website

Dental Insurance

Primary Dental Carrier

Subscriber Name: _____ Social Security #: _____ DOB: _____

Insurance Co: _____ Insurance Phone# _____

Employer: _____ Group #: _____ Relationship to patient: _____

Secondary Dental Carrier

Subscriber Name: _____ Social Security #: _____ DOB: _____

Insurance Co: _____ Insurance Phone #: _____

Employer: _____ Group #: _____ Relationship to patient: _____

Insurance Authorization Statement (Sign & Date) I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs and dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the medical history is correct to the best of my knowledge.

Signature: _____ Date: _____

If Patient is Under 18

Responsible Party: _____ Relation to Patient: _____

Address: Street_____

City:_____ State:_____ Zip Code:_____ Phone:_____

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Health History

Patient's Name: _____ Date: _____

Circle "Yes" or "No" to indicate if you have had any of the following:

CONDITIONS

Abnormal Bleeding	Yes	No	High Blood Pressure	Yes	No	Do you smoke?	Yes	No
Allergies	Yes	No	Joint Replacement	Yes	No	If yes, how often?		
Anemia	Yes	No	Kidney Problems	Yes	No	Check all that apply:		
Angina Pectoris	Yes	No	Liver Disease	Yes	No	Vape		
Arthritis	Yes	No	Low Blood Pressure	Yes	No	Chewing Tobacco		
Artificial Heart Valve	Yes	No	Lupus	Yes	No	Medical Marijuana		
Asthma	Yes	No	Mitral Valve Prolapse	Yes	No			
Autism	Yes	No	Pacemaker	Yes	No	IF FEMALE:		
Blood Transfusion	Yes	No	Psychiatric Problems	Yes	No	Are you taking birth control?	Yes	No
Cancer	Yes	No	Radiation Therapy	Yes	No	Are you pregnant?	Yes	No
Chemotherapy	Yes	No	Respiratory Problems	Yes	No	If yes, how many weeks?		
Colitis	Yes	No	Rheumatic Fever	Yes	No	Are you nursing?	Yes	No
Congenital Heart Defect	Yes	No	Seizures	Yes	No			
Diabetes	Yes	No	Shingles	Yes	No			
Difficulty Breathing	Yes	No	Sickle Cell Disease	Yes	No			
Drug/Alcohol Abuse	Yes	No	Sinus Problems	Yes	No			
Down Syndrome	Yes	No	Sjogren's Syndrome	Yes	No			
Emphysema	Yes	No	Stroke	Yes	No			
Epilepsy	Yes	No	Thyroid	Yes	No			
Facial Surgery	Yes	No	Tuberculosis	Yes	No			
Fainting Spells	Yes	No	Ulcers	Yes	No			
Fever Blisters	Yes	No	Venereal Disease	Yes	No			
Frequent Headaches	Yes	No						
Glaucoma	Yes	No						
HIV/ AIDS	Yes	No						
Heart Attack	Yes	No						
Heart Murmur	Yes	No						
Heart Surgery	Yes	No						
Hemophilia	Yes	No						
Hepatitis A	Yes	No						
Hepatitis B	Yes	No						
Hepatitis C	Yes	No						

ALLERGIES:

Aspirin	Yes	No
Codeine	Yes	No
Dental Anesthetics	Yes	No
Erythromycin	Yes	No
Latex	Yes	No
Metals	Yes	No
Penicillin	Yes	No
Sulfa	Yes	No
Tetracycline	Yes	No

Other:_____

MEDICATIONS:

(List any medications you are currently taking)

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Patients Signature: _____ Date: _____

If under 18 Parent/ Responsible Party's Signature: _____ Doctor's Signature: _____

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DENTAL EVALUATION

Patient's Name:_____ Date:_____

Is there anything about your smile that you don't like? _____

Do you have any missing teeth? _____

Is your bite comfortable for chewing, biting? _____

Do you have any old fillings or dental work that you don't like? _____

Would you be interested in enhancing your smile with whiter, more aligned teeth? ☐ Yes ☐ No

If nervous, would you like to have your dentistry done with laughing gas (nitrous oxide)? ☐ Yes ☐ No

Is there anything about your mouth that concerns you now? ☐ Yes ☐ No

If yes, please explain:_____

When was your last cleaning?_____

Were X-Rays taken at this last visit? ☐ Yes ☐ No

Have you ever had orthodontic treatment? ☐ Yes ☐ No

Do you use dental floss or toothpicks? ☐ Yes ☐ No

Have you ever had your wisdom teeth removed? ☐ Yes ☐ No

Do your gums ever bleed? ☐ Yes ☐ No

Are any of your teeth loose? ☐ Yes ☐ No

Do you have any swelling, sores or blisters in your mouth? ☐ Yes ☐ No

Have you ever been told that you have gum disease? ☐ Yes ☐ No

Have you ever visited a periodontist (gum specialist)? ☐ Yes ☐ No

Do you smoke? ☐ Yes ☐ No

Do you feel you have unpleasant breath at times? ☐ Yes ☐ No

Are you interested in using sedatives while dental treatment is being performed? ☐ Yes ☐ No

How would you describe your dental health on a scale of 1-10 with 10 being the best? _____

Is there anything else we should know about? Have you had any prior dental experiences that were not pleasant? Is there anything that we can do to make your dental visits more comfortable?_____

_____

_____

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Patient Acknowledgement of receipt of Dental Materials Fact Sheet

I _____ acknowledge that I have read/received a copy of the Dental Materials Fact Sheet from Andrew Tibbitts DDS & Associates.

_____ _____

Patient Signature Date

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OFFICE POLICY

NO SHOW AND CANCELLATION

In order to continue providing excellent quality, yet affordable dental services, it is important for our patients to understand that appointments are reserved for you in advance; please make every effort to keep your appointments. You must notify us within 48 hours if you need to reschedule or cancel your appointment, there will be a fee of $50-100 (depending on appointment type)

A $250.00 deposit will be required to reserve an appointment for your surgery date. This fee will then be applied to dental work that is scheduled to be done.

PATIENTS WITH DENTAL INSURANCE

It is your responsibility to provide our office with your dental plan and to let us know of any changes at your appointment. We will continue to try and help you understand your policy but please be aware that there are thousands of different policies and we do not know all of the limitations for all the plans out there. If for any reason your insurance company does not pay for a procedure, the balance is your responsibility to pay in full upon receipt of the statement.

I AM RESPONSIBLE FOR MY BALANCE IF ANY OF THE FOLLOWING OCCUR:

- The treatment goes over my yearly maximum.
- Any treatment that is denied by my insurance company.
- I am not eligible for insurance.
- I prevent or delay by not complying with requests for insurance forms or signatures.
- I do not complete my treatment and it results in non-payment by the insurance company.
- Lab and equipment costs that incurred due to a missed appointment.
- I received my insurance check and did not send it to the office.

By signing this, I have read and understood the above policy.

_____ _____

Patient Signature Date