ANDREW TIBBITTS DDS & ASSOCIATES

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Phone: 951.677.5113 - Fax: 951.900.6148

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 #: ________________ Driver's License #: ______________

Marital Status: ☐Single ☐Married ☐Separated ☐Divorced ☐Widowed If applicable, Spouses Name: ________________

Patient's Email: ____

Home (_____)____________________ Work (_____)____________________ Mobile (_____)____________________

Emergency Contact Name: ____________________________________ **Phone:** (_____)________________________

How would you like to receive appointment reminders? (Please circle): Phone Call Email Text

Employer: ____ May we contact you at work? ☐ Yes ☐ No

How did you hear about us? ____

DENTAL INSURANCE

Primary Dental Carrier

Subscriber Name: ______________________________ Social Security #: ___________________ DOB: ____________

Insurance Co: ____ Insurance Phone #: __________________________

Employer: ____________________________________ Group #: ________________ Relation to patient: ______________

Secondary Dental Carrier

Subscriber Name: ______________________________ Social Security #: ___________________ DOB: ____________

Insurance Co: ____ Insurance Phone #: __________________________

Employer: ____________________________________ Group #: ________________ Relation 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: ______________________________

ANDREW TIBBITTS DDS & ASSOCIATES

Patient's Name: ______________________________ DOB: ____________ Date: ____________

HEALTH HISTORY

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

CONDITIONS

Condition	Yes	No
Abnormal Bleeding	☐ Yes	☐ No
Allergies	☐ Yes	☐ No
Anemia	☐ Yes	☐ No
Angina Pectoris	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No
Artificial Heart Valve	☐ Yes	☐ No
Asthma	☐ Yes	☐ No
Blood Transfusion	☐ Yes	☐ No
Cancer	☐ Yes	☐ No
Chemotherapy	☐ Yes	☐ No
Colitis	☐ Yes	☐ No
Congenital Heart Defect	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Difficulty Breathing	☐ Yes	☐ No
Drug/Alcohol Abuse	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No
Epilepsy	☐ Yes	☐ No
Facial Surgery	☐ Yes	☐ No
Fainting Spells	☐ Yes	☐ No
Fever Blisters	☐ 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
High Blood Pressure	☐ Yes	☐ No
Joint Replacement	☐ Yes	☐ No
Kidney Problems	☐ Yes	☐ No
Leukemia	☐ Yes	☐ No
Liver Disease	☐ Yes	☐ No
Low Blood Pressure	☐ Yes	☐ No
Lupus	☐ Yes	☐ No
Mitral Valve Prolapse	☐ Yes	☐ No
Pace Maker	☐ Yes	☐ No
Psychiatric Problems	☐ Yes	☐ No
Radiation Therapy	☐ Yes	☐ No
Respiratory Problems	☐ Yes	☐ No
Rheumatic Fever	☐ Yes	☐ No
Seizures	☐ Yes	☐ No
Shingles	☐ Yes	☐ No
Sickle Cell Disease	☐ Yes	☐ No
Sinus Problems	☐ Yes	☐ No
Sjogren's Syndrome	☐ Yes	☐ No
Stroke	☐ Yes	☐ No
Thyroid	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No
Ulcers	☐ Yes	☐ No
Venereal Disease	☐ Yes	☐ No

ALLERGIES

Allergy	Yes	No
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: ______________________________
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Do you smoke? ☐ Yes ☐ No

IF FEMALE

Are you taking birth control? ☐ Yes ☐ No
Are you pregnant? ☐ Yes ☐ No
If yes, how many weeks? __________
Are you nursing? ☐ Yes ☐ No

MEDICATIONS: (List any medications you are currently taking)

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Patient's Signature: ______________________________ Date: ____________

If under 18 Parent/Responsible Party's Signature: ______________________________

Doctor Review: ______________________________

DENTAL EVALUATION

Patient's Name: ____ DOB: _____________ 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 were you last seen at the Dentist? What treatment was done? ____

____

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? ____

____

____

Patient Acknowledgement of receipt of Dental Materials Fact Sheet

Patient's Name: ____DOB:_____________ Date: ____________

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

____ ________________

Patient Signature Date

OFFICE POLICY

Patient's Name: ____DOB:_____________ Date: ____________

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. **If you fail to inform our office 48 hours prior your next scheduled appointment, you will be subject to a cancellation/no show fee. This fee can range between $50-$75, depending on the appointment.** 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 do not sent it to the office.

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

____ ____________________

Patient Signature Date