



# Legacy Dental

40710 California Oaks Road Suite B,  
Murrieta, CA 92562  
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 #: \_\_\_\_\_ DL#: \_\_\_\_\_

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?:  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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Patient's Name: \_\_\_\_\_ Date: \_\_\_\_\_

## HEALTH HISTORY

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

### Conditions:

- Abnormal Bleeding  Yes  No
- Allergies  Yes  No
- Anemia  Yes  No
- No
- Angina Pectoris  Yes  No
- 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
- Heart Attack  Yes  No
- Heart Murmur  Yes  No
- Heart Surgery  Yes  No
- Hemophilia  Yes  No
- Hepatitis A/B/ or C  Yes  No
- High Blood Pressure  Yes  No
- HIV/ AIDS  Yes  No
- Joint Replacement  Yes  No
- Kidney Problems  Yes  No

- Liver disease  Yes  No
- Low Blood Pressure  Yes  No
- Lupus  Yes  No
- Mitral Valve Prolapse  Yes  No
- Pacemaker  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

If Female:

Are you taking birth control?  Yes

Are you pregnant?  Yes

If yes, how many weeks? \_\_\_\_\_

Do you smoke?  Yes  No

If yes, how often ? \_\_\_\_\_

Check any that apply:

- Vape
- Chewing Tobacco
- Medicinal marijuana

### Medications :

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### 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 : \_\_\_\_\_

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If under 18 Parent/Responsible Party's Signature: \_\_\_\_\_ Doctor Review: \_\_\_\_\_



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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 if \$50 - \$75 if you do not give us proper notice.** 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** \_\_\_\_\_