WELCOME
TO OUR PRACTICE!

Please take a few minutes to answer the following questions so we can better assist you with your dental needs.

PATIENT INFORMATION

Date _____ Soc. Sec. # _____ Birthdate _____

Name _____ Home Phone _____
Last Name First Name Initial

Address _____ Cell Phone _____

City _____ State _____ Zip _____ E-mail _____

Sex: ☐ M ☐ F ☐ Minor ☐ Single ☐ Married ☐ Long Term Partner ☐ Divorced ☐ Widowed ☐ Separated

Employer _____ Business Phone _____

Business Address _____ Occupation _____

Who should we thank for referring you? _____

In case of emergency, who should we contact? _____ Phone _____

PRIMARY DENTAL INSURANCE

Person Responsible for Account _____
Last Name First Name Initial

Relationship to Patient _____ Birthdate _____ Soc. Sec. # _____

Address _____ Home Phone _____

City _____ State _____ Zip _____

Responsible Party Employed By _____ Business Phone _____

Business Address _____ Occupation _____

Insurance Company _____

Insurance Company Address _____

Subscriber I.D. # _____ Group # _____

ADDITIONAL INSURANCE

Insured Name _____
Last Name First Name Initial

Relationship to Patient _____ Birthdate _____ Soc. Sec. # _____

Address _____ Home Phone _____

City _____ State _____ Zip _____

Insured Employed By _____ Business Phone _____

Insurance Company _____

Insurance Company Address _____

Subscriber I.D. # _____ Group # _____

Please complete reverse side

DENTAL HISTORY

Former Dentist _____ Date of Last X-Rays _____

City, State _____ How Often Do You Floss? _____

Date of Last Dental Visit _____ How Often Do You Brush? _____

Please check all that apply:

- Bad Breath ☐
- Bleeding Gums ☐
- Blisters on Lips or Mouth ☐
- Finger Nail Biting ☐
- Grinding Teeth ☐
- Lip or Cheek Biting ☐
- Loose Teeth or Broken Fillings ☐
- Orthodontic Treatment ☐
- Pain Around Ear ☐
- Periodontal Treatment ☐
- Sensitivity to Cold ☐
- Sensitivity to Heat ☐
- Sensitivity to Sweets ☐
- Sensitivity When Biting ☐
- Frequent Headaches ☐
- Jaw, Head or Neck Injuries ☐
- Jaw Difficulty: Clicking and/or Pain ☐
- Tooth Pain ☐

MEDICAL HISTORY

Physician's Name _____ Date of Last Visit _____

	Yes	No
1. Are you currently under medical treatment?	☐	☐
2. Have you ever had any serious illnesses or operations?	☐	☐
3. Are you currently taking any medication?	☐	☐
Please describe: _____		
4. Do you smoke?	☐	☐
5. Do you use alcohol, cocaine or other drugs?	☐	☐
6. Do you wear contact lenses?	☐	☐

7. Have you had any allergic reactions to the following:

	Yes	No
Local Anesthetics (eg. novocaine)	☐	☐
Penicillin or other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates (sleeping pills)	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Other	☐	☐

8. (Women Only) Are You:

Pregnant?	☐	☐
Nursing?	☐	☐
Taking birth control pills?	☐	☐

Please check all that apply:

- AIDS ☐
- Anemia ☐
- Arthritis, Rheumatism ☐
- Artificial Heart Valves ☐
- Artificial Joints ☐
- Asthma ☐
- Back Problems ☐
- Bleeding abnormally, with extractions or surgery ☐
- Blood Disease ☐
- Cancer ☐
- Chemical Dependency ☐
- Chemotherapy ☐
- Chronic Fatigue Syndrome ☐
- Circulatory Problems ☐
- Congenital Heart Lesions ☐
- Cortisone Treatments ☐
- Cough - persistent or bloody ☐
- Diabetes ☐
- Emphysema ☐
- Epilepsy ☐
- Fainting or Dizziness ☐
- Glaucoma ☐
- Headaches ☐
- Heart Murmur ☐
- Heart Problems ☐
- Hepatitis-Type _____ ☐
- Herpes ☐
- High Blood Pressure ☐
- HIV Positive ☐
- Jaundice ☐
- Jaw Pain ☐
- Latex Sensitivity ☐
- Kidney Disease ☐
- Liver Disease ☐
- Low Blood Pressure ☐
- Mitral Valve Prolapse ☐
- Nervous Problems ☐
- Pacemaker ☐
- Psychiatric Care ☐
- Radiation Treatment ☐
- Respiratory Disease ☐
- Rheumatic Fever ☐
- Scarlet Fever ☐
- Shortness of Breath ☐
- Sinus Trouble ☐
- Skin Rash ☐
- Stroke ☐
- Swelling of Feet/Ankles ☐
- Swollen Neck Glands ☐
- Thyroid Problems ☐
- Tonsillitis ☐
- Tuberculosis ☐
- Tumor or growth on head/neck ☐
- Ulcer ☐
- Venereal Disease ☐

ASSIGNMENT AND RELEASE

I hereby authorize payment directly to DR. ADAM D. CLOCK for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

I authorize the above doctor and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party _____ Date _____

WRITTEN FINANCIAL POLICY

Thank you for choosing Tipton Park Dentistry.
Our primary mission is to deliver quality, comprehensive dental care.

Payment Options Include: Cash, Check, Visa, MasterCard, Discover, Debit Cards, CareCredit* (pre-approval required), and In-House Tipton Park Dentistry Payment Plans (pre-approval required)

Payment (including copays, deductibles, and previous account balances) is due on the day of service. **We accept most insurances, however, we are an "in-network" provider for Delta Dental (Premier) and SIHO. For all other dental insurance providers, we are considered an "out of network" provider.** As a courtesy, we will file your insurance and accept assignment of benefits. In order for us to do this, you must provide us with accurate and up-to-date insurance information and a copy of your insurance cards.

Estimates - We try our best to maximize the benefits of your insurance plan and provide accurate estimates for treatment. 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 necessarily, 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 fully 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 filing**. If payment is not received, 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, if payment has not been made, the balance will then become your responsibility.

Overdue Balances - If your account has an unpaid balance, we will do our best to remind you with monthly statements, phone calls, emails and/or texts. Any unpaid balance over 90 days will be considered delinquent and turned over to Allied Collection Service. We reserve the right to release any necessary information required to collect for services rendered. 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 value all of our patients' time. 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. This will allow us to reserve your appointment time for another patient. If you miss 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. In the case of a divorce, regardless of 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 - If you choose to discontinue care before treatment is complete, a possible refund 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 Date

_____
Patient, Parent, or Guardian Signature

*CareCredit is a special healthcare financing program. There is no application fee, no down payment, and the terms of your obligation can be interest-free. Please ask a staff member or check out our website, www.tiptonparkdentistry.com CareCredit Logo Link, for more information.

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.)

_____
(Please Print Name)

_____
(Signature)

_____
(Date)

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

Individual refused to sign Communications barrier Emergency situation