TRIPPE
DENTISTRY

Welcome

Thank you for trusting us with your health care. We promise to do our best to provide you with the finest care available. If you have any questions please do not hesitate to call us.

Patient Information

Date _____ ID#/SS# _____

Patient _____

Address _____

_____

Sex: ❑ M ❑ F Age _____ Birthdate _____

❑ Single ❑ Married ❑ Widowed ❑ Separated ❑ Divorced

Occupation _____

Employer _____

Employer Address _____

Employer Phone (_____)_____

Spouse's Name _____

Birthdate _____ SS# _____

Occupation _____

Spouse's Employer _____

Whom may we thank for referring you? _____

Dental Insurance

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ❑ Yes ❑ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient_____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____

Responsible Party Signature

_____

Relationship Date

Patient Information

Home (_____) _____ **Work** (_____) _____ Ext. _____ **Cell** (_____) _____

Email (for appointment notification only) _____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name _____ Relationship _____

Home Phone (_____) _____ Work Phone (_____) _____

Dental History

Reason for today's visit _____

_____

Former Dentist_____

City/State_____

Date of last dental visit _____

Date of last dental X-rays _____

Place a mark on "yes" or "no" to indicate if you have had any of the following:

Bad Breath ❑ Yes ❑ No
Bleeding Gums ❑ Yes ❑ No
Blisters on lips or mouth ❑ Yes ❑ No
Cigarette, pipe, or cigar smoking ❑ Yes ❑ No
Clicking or popping jaw ❑ Yes ❑ No
Dry mouth ❑ Yes ❑ No
Grinding teeth ❑ Yes ❑ No
Gums swollen or tender ❑ Yes ❑ No
Jaw pain or tiredness ❑ Yes ❑ No
Orthodontic Treatment ❑ Yes ❑ No
Periodontal treatment ❑ Yes ❑ No
Sensitivity to cold ❑ Yes ❑ No
Sensitivity to heat ❑ Yes ❑ No
Sensitivity to sweets ❑ Yes ❑ No
Sensitivity when biting ❑ Yes ❑ No
Sores or growths in your mouth ❑ Yes ❑ No

How often do you floss? _____

How often do you brush? _____

OVER

Health History

Physician's Name _____ Date of last visit _____

Place a mark on "yes" or "no" to indicate if you have had any of the following:

AIDS/HIV	❑ Yes	❑ No	Emphysema	❑ Yes	❑ No	Radiation Treatment	❑ Yes	❑ No
Anemia	❑ Yes	❑ No	Epilepsy	❑ Yes	❑ No	Respiratory Disease	❑ Yes	❑ No
Arthritis, Rheumatism	❑ Yes	❑ No	Fainting or dizziness	❑ Yes	❑ No	Rheumatic Fever	❑ Yes	❑ No
Artificial Heart Valves	❑ Yes	❑ No	Glaucoma	❑ Yes	❑ No	Scarlet Fever	❑ Yes	❑ No
Artificial Joints	❑ Yes	❑ No	Headaches	❑ Yes	❑ No	Shortness of Breath	❑ Yes	❑ No
Asthma	❑ Yes	❑ No	Heart Murmur	❑ Yes	❑ No	Sinus Trouble	❑ Yes	❑ No
Back Problems	❑ Yes	❑ No	Heart Problems	❑ Yes	❑ No	Skin Rash	❑ Yes	❑ No
Bleeding abnormally, with extractions or surgery	❑ Yes	❑ No	Hepatitis Type _____	❑ Yes	❑ No	Special Diet	❑ Yes	❑ No
			Herpes	❑ Yes	❑ No	Stroke	❑ Yes	❑ No
Blood Disease	❑ Yes	❑ No	High Blood Pressure	❑ Yes	❑ No	Swollen Feet or Ankles	❑ Yes	❑ No
Cancer	❑ Yes	❑ No	Jaundice	❑ Yes	❑ No	Swollen Neck Glands	❑ Yes	❑ No
Chemical Dependency	❑ Yes	❑ No	Jaw Pain	❑ Yes	❑ No	Thyroid Problems	❑ Yes	❑ No
Chemotherapy	❑ Yes	❑ No	Kidney Disease	❑ Yes	❑ No	Tonsilitis	❑ Yes	❑ No
Circulatory Problems	❑ Yes	❑ No	Liver Disease	❑ Yes	❑ No	Tuberculosis	❑ Yes	❑ No
Congenital Heart Lesions	❑ Yes	❑ No	Low Blood Pressure	❑ Yes	❑ No	Tumor or growth on head or neck	❑ Yes	❑ No
Cortisone Treatments	❑ Yes	❑ No	Mitral Valve Prolapse	❑ Yes	❑ No			
Cough, persistent or bloody	❑ Yes	❑ No	Nervous Problems	❑ Yes	❑ No	Ulcer	❑ Yes	❑ No
Diabetes	❑ Yes	❑ No	Pacemaker	❑ Yes	❑ No	Veneral Disease	❑ Yes	❑ No
			Psychiatric Care	❑ Yes	❑ No	Weight loss, unexplained	❑ Yes	❑ No

Do you wear contact lenses? ❑ Yes ❑ No

Women:
Are you pregnant? ❑ Yes ❑ No Due date _____ Are you nursing? ❑ Yes ❑ No
Taking birth control pills? ❑ Yes ❑ No

Medications

List any medications you are currently taking and the correlating diagnosis:

_____

_____

_____

Pharmacy Name _____

Phone (_____) _____

Allergies

❑ Aspirin ❑ Local Anesthetic

❑ Barbiturates (Sleeping Pills) ❑ Penicillin

❑ Codeine ❑ Sulfa

❑ Iodine ❑ Other _____

❑ Latex _____ _____

Acknowledgement of Receipt of Notice of Privacy Practices

I, _____ have received a copy of the Leslie H. Trippe D.D.S., Inc. Notice of Privacy Practices Form.
(Name of Patient)

_____
(Signature of Patient)

Staff Will Fill Out This Section If Patient's Signature Not Obtained

Our office made a good faith effort to obtain Acknowledgment of Receipt of our Notice of Privacy Practices, but it was not obtained for the following reasons:

_____ Patient refused to sign.

_____ Emergency situation kept us from obtaining the patient's signature.

_____ Language barriers kept us from obtaining the patient's signature

_____ Other situation. _____

Acknowledgement of Financial Policy

Welcome to Trippe Dental! As a courtesy to our patients, we will gladly file your insurance once your coverage has been confirmed. At the time of service, we will ask you to pay your estimated patient portion plus any deductible that may apply. Since we can only estimate what your insurance company will pay, you may be left with either a credit or a balance due. You can apply the credit to future dental care, or request a refund. Otherwise, a statement will be mailed if there is a balance due.

We accept cash, checks, Visa, MasterCard, Discover Card or Care Credit. A 5% discount is offered to those who want to pre-pay their entire treatment plan, payable only with cash or check. *

If your account becomes delinquent, a 5% finance charge may be applied, per month to the past due balance. Delinquency is defined by 60 days past due. Any account that is sent to collections will receive a collection fee.

Patients Signature Date

***The 5% discount excludes Delta Dental members**.