Roger D. Tipton, D.D.S., M.S., P.A.
dentistry for kids
6102-82nd Street, Suite 2
Lubbock, TX 79424
(806) 792-2288

CONFIDENTIAL PATIENT INFORMATION:

Today's Date: _____

Patient's Name: _____ Preferred Name: _____

Date of Birth: _____ Social Security #: _____ Female: ❑ Male: ❑

Name(s) and ages of sibling(s) that are current patient(s): _____

_____

CONFIDENTIAL RESPONSIBLE PARTY:

❑ Mother ❑ Stepmother ❑ Guardian Marital Status: _____

Name: _____ SS#: _____

Address: _____

City State Zip

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Emergency #: _____ Relationship: _____ Date of Birth: _____

Email Address: _____ DL#: _____

❑ Father ❑ Stepfather ❑ Guardian Marital Status: _____

Name: _____ SS#: _____

Address: _____

City State Zip

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Emergency #: _____ Relationship: _____ Date of Birth: _____

Email Address: _____ DL#: _____

PRIMARY DENTAL INSURANCE:

Insured's Name: _____ Relationship: _____

Date of Birth: _____ SS#: _____

Employer: _____ Employer Phone #: _____

Employer Address: _____

Insurance Co.: _____ Ins. Co. Phone #: _____

Insurance Co. Address: _____

Policy #: _____ Group #: _____

ADDITIONAL DENTAL INSURANCE:

Insured's Name: _____ Relationship: _____

Date of Birth: _____ SS#: _____

Employer: _____ Employer Phone #: _____

Employer Address: _____

Insurance Co.: _____ Ins. Co. Phone #: _____

Insurance Co. Address: _____

Policy #: _____ Group #: _____

PEDIATRICIAN:

Name of Pediatrician: _____ Date of last visit: _____

Present Problem requiring Dental Treatment: _____

_____

Who may we thank for your referral? _____

Continued on reverse side

MEDICAL HISTORY

Has your child ever had any of the following: (Check *Yes* or *No*. If *Yes*, please explain.)

Yes	No	Condition	Explanation
		Is your child taking any medication?	
		Does your child have asthma?	
		Allergies to medicine? If so, please list.	
		Allergies to food? If so, please list.	
		Latex allergies?	
		Immunizations up-to-date?	
		Has your child had any recent illness in the last month?	
		Has your child been exposed to any infectious illness?	
		Previous Hospitalizations or Surgeries?	
		Difficulty with previous anesthesia?	
		Seizures or Convulsions?	
		Birth Defects?	
		Brain Damage / Neurological Problems / Learning Disorder?	
		Serious Illness?	
		Heart Disease / Murmur / Rheumatic Fever?	
		Diabetes?	
		Other?	
		Fainting spells, Dizziness or Breath Holding Spells?	
		Is your child still nursing?	
		Does your child still take a bottle?	

Has your child had frequent problems with:

Yes	No	Condition	Yes	No	Condition
		Colds			Joint or Muscle Problems
		Sore Throat			Headaches
		Ear Infection			Eye Problems
		Pneumonia			Bruise Easily
		Stomach or Bowel Problems			Bleeding Problems
		Bronchitis			Nose Bleeds
		Bladder or Kidney Problems			Other

Does your child <u>now</u> have:

Yes	No	Condition	Explanation
		Rash	
		Sores	
		Eczema	
		Dry Itchy Skin	
		Head Lice	

Is there a family history of:

Yes	No	Condition	Explanation
		Diabetes	
		Any Bleeding Problems	
		Neuromuscular Problems	
		Trouble with Anesthesia	
		Heart Disease	
		Other	

I authorize the dentist to perform diagnostic procedures (exam, x-rays, cleaning) and treatment as may be necessary for proper dental care. I understand that responsibility for full payment of dental services is mine, and is expected when services are rendered, unless other arrangements have been made in advance. I hereby authorize payment of insurance benefits directly to the dentist, otherwise payable to me. I understand there will be a $30.00 charge for all return checks, in addition to my account becoming a *cash only* account. I understand there may be a $100.00 collection fee for any balance turned over to an outside collection agency. I understand that there will be a fee charged for failed appointments. I attest to the accuracy of the information on this form.

Parent / Guardian Signature: _____ Date: _____