

Roger D. Tipton, D.D.S., M.S., P.A.

dentistry for kids
6102-82nd Street
Lubbock, TX 79424
(806) 792-2288

PATIENT INFORMATION:

Patient's Name: _____ Today's Date: _____
Nickname: _____
Date of Birth: _____ Social Security #: _____ Female: Male:
Name(s) of sibling(s) that are current patient(s): _____

RESPONSIBLE PARTY:

Name: _____ Relationship: _____
Address: _____
City State Zip
Social Security #: _____ DL#: _____

PARENT / GUARDIAN INFORMATION:

Mother Stepmother Guardian
Name: _____ DL#: _____
Home Phone: _____ Work Phone: _____ SS#: _____
Cell Phone #: _____ Emergency #: _____ Date of Birth: _____
Email Address: _____

Father Stepfather Guardian
Name: _____ DL#: _____
Home Phone: _____ Work Phone: _____ SS#: _____
Cell Phone #: _____ Emergency #: _____ Date of Birth: _____
Email Address: _____

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? _____

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 now 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 \$25.00 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: _____