

Jeffrey J. Tibbs, D.D.S., P.A.

3455 HEALY DRIVE
WINSTON-SALEM, NC 27103
Telephone (336) 765-7477

MEDICAL ALERT FOR OFFICE USE:

PATIENT INFORMATION

DATE _____

NAME _____
LAST FIRST MI PREFER TO BE CALLED

ADDRESS _____
STREET APT. NO.

CITY STATE ZIP

REFERRED TO THIS OFFICE BY _____

BIRTHDATE _____ OCCUPATION _____

TELEPHONE HOME _____ CITY _____

BUSINESS _____ E-MAIL _____

CELL _____ SOCIAL SECURITY NUMBER _____

EMPLOYER _____

EMPLOYER ADDRESS _____

MALE FEMALE

EMERGENCY: NAME _____ PHONE _____

DENTAL INSURANCE

PRIMARY CARRIER _____

SECONDARY CARRIER _____

AUTHORIZATION

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 cost 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 are correct to the best of my knowledge.

* SIGNATURE _____ DATE _____

OTHER INFORMATION - RESPONSIBLE PARTY

NAME _____
LAST FIRST MIDDLE INITIAL

ADDRESS _____
STREET APT. NO.

CITY STATE ZIP

EMPLOYER _____

BIRTHDATE _____

TELEPHONE BUSINESS _____

SOCIAL SECURITY NUMBER _____

PATIENT MEDICAL/DENTAL HISTORY

Jeffrey J. Tibbs, D.D.S., P.A.

Name _____ Date _____

What is the reason for today's visit? _____

Do you have any questions or concerns we can help you with today? _____

If there was a simple, inexpensive way to whiten your teeth, would you be interested? _____

If you could wave a magic wand and change one thing about your smile, what would it be? _____

Are you interested in avoiding bad breath? _____

Are you interested in a simple, non-surgical way to end your or your spouse's snoring? _____

Why did you leave your last dentist? _____

What did you like most about any dentist you've ever seen? _____

What did you like least about any dentist you've ever seen? _____

MEDICAL HISTORY AND INFORMATION

Do you have or ever had?

- Arthritis
- Asthma
- Cancer
- Diabetes
- Epilepsy
- Glaucoma
- Heart Murmur
- Heart Problem
- Hepatitis
- High Blood Pressure
- HIV Positive
- Jaundice
- Joint Replacement
- Kidney Problems
- Low Blood Pressure
- Mitral Valve Prolapse
- Rheumatic Fever
- Sexually Transmitted Diseases
- Stroke
- Tuberculosis
- Other _____

Are you allergic to?

- Aspirin Codeine
- Barbiturate Penicillin
- Other _____

Are you currently taking any prescription medications?

- YES NO

If yes please list _____

Are you currently under the care of a physician?

- YES NO

Please explain _____

Female Patients: Are you pregnant?

- YES NO

If yes, due date _____

I authorize and give consent to perform dental services agreed between doctor and patient and/or parent or guardian to be necessary or advisable including the use of local anesthesia and other medication as indicated. I certify to the above statements regarding my medical condition.

Payment for all treatment and services rendered are my responsibility.

Patient's Signature

Date

If patient is child or requires a guardian:

Parent or Guardian's Signature

Date