Welcome

Today's Date_____

Patient Information

Patient Name _____ *Preferred*_____
Last *First* *MI*

Sex: ☐ *male* ☐ *female* *Status:* ☐ *minor* ☐ *single* ☐ *married* ☐ *divorced* ☐ *other*

Birthdate _____ *Social Security #*_____

*Mailing Address*_____ *City*_____ *State*_____ *Zip*_____

*Home Phone#*_____ *Work#*_____ *Ext #*_____

Please put the best phone number & e-mail for us to call, or text to confirm your appointments!

*Cell Phone#*_____ *E-mail*_____

*Employer*_____ *Address*_____

Who may we thank for referring you to us? _____

*EmergencyContact*_____ *Phone#*_____

Primary Insurance Information

*Insurance Co. Name*_____ *Phone#*_____

*Subscriber Name*_____ *Birthdate*_____ *SS #*_____

*Relationship to patient*_____ *Employer* _____

*Subscriber ID #*_____ *Group # (plan or policy)*_____

Secondary Insurance Information

*Insurance Co. Name*_____ *Phone#*_____

*Subscriber Name*_____ *Birthdate*_____ *SS #*_____

*Relationship to patient*_____ *Employer* _____

*Subscriber ID #*_____ *Group # (plan or policy)*_____

Person Responsible For Account

*Name*_____ *SS#*_____ *Phone #*_____

Billing Address _____ *Relationship to Patient*_____

Authorization: ***I hereby authorize payment directly to Dr. Jeffrey J. Tibbs, DDS, PA for all insurance benefits otherwise payable to me for services rendered, and the use of this signature on all insurance submissions. 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 dependants. I understand it is my responsibility to notify the dental office of any changes to my insurance benefits. I acknowledge that the dental office reserves the right to request payment in full at the time services are rendered.***

Initials _____ ***I acknowledge that I have received a copy of the Summary of Privacy Notice & Financial Policy.***

Signature _____ ***Date***_____

MEDICAL HISTORY UPDATE

Patient Name_____Birthdate_____Date_____

List allergies to drugs / materials / foods_____

List current medications_____

Pre-Med Required? YES NO If yes, reason_____type_____dosage_____

Tobacco user? YES NO If yes, type_____ amount_____ number of years_____

Female patients: Are you pregnant? YES NO If yes, due date_____

PAST AND CURRENT MEDICAL CONDITIONS (MARK ALL THAT APPLY):

CONDITION	YES	NO
Under physician's care? Details:		
Hospitalization in last 5 years? Details:		
Past use of Fen-Phen?		
Heart trouble / disease?		
Rheumatic fever?		
Heart murmur?		
Mitral valve prolapse?		
Heart Surgery?		
Artificial heart valves?		
Pacemaker and/or defibrillator?		
Artificial joints?		
History of organ transplant?		
High/Low blood pressure?		
Stroke?		
Bleeding problem?		
Hemophilia?		
Anemia?		
Leukemia?		
Lung disease?		
Emphysema?		
Shortness of breath?		
Asthma?		
Sleep apnea?		
Tuberculosis?		
Sinus trouble?		
Cancer?		
Radiation treatment to head/neck?		

CONDITION	YES	NO
Past use of Bisphosphonates (eg. Aredia / Fosomax)?		
History of infective endocarditis?		
Chemotherapy?		
Kidney disease?		
Dialysis?		
Eating disorder?		
G.I. problems: reflux? Ulcer?		
Immunological disease?		
Sjogrens disease?		
Fibromyalgia?		
Other autoimmune disease (eg. lupus, pemphilus)?		
Jaw pain?		
Arthritis or other joint disorders?		
Diabetes? Type: Controlled? Y N		
Hypoglycemia?		
Severe/frequent headaches?		
Diagnosed depression?		
Neurologic disorders?		
Convulsions?		
Epilepsy / seizures?		
Fainting/ dizziness?		
AIDS / HIV positive?		
Sexually transmitted disease?		
Hepatitis?		
Thyroid disease?		
Glaucoma?		
Alcohol or chemical dependency?		

AUTHORIZATION: ***I have reviewed the information and it is accurate to the best of my knowledge. I understand it is my responsibility to inform the office of Jeffrey J. Tibbs, DDS, PA of any changes to the information I have provided.***

Signature_____Date_____

_____adult patient _____parent or guardian

Dr. Jeffrey J. Tibbs, DDS

Acknowledgment of Receipt of Notice of Privacy Practices

Patient Name: _____

Patient Address: _____

I have received a copy of the Notice of Privacy Practices for the above named practice.

_____ _____

Signature Date

For Office Use Only

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

- An emergency existed & a signature was not possible at the time.
- The individual refused to sign.
- A copy was mailed with a request for a signature by return mail.
- Unable to communicate with the patient for the following reason:
  _____
  _____
- Other: _____
  _____
  _____
-

Prepared by: _____

_____ _____

Signature **Date**

Jeffrey J. Tibbs, DDS, PA

3455 Healy Drive

Winston Salem, NC 27103

Informed Consent:

I ,authorize and give consent to perform dental services agreed between Jeffery J. Tibbs dental office and patient, parent or guardian to be necessary or advisable including routine hygiene, xrays, the use of local anesthesia and other medication as indicated.

I, the undersigned, hereby authorize the doctor to take radiographs, study models, photographs or any other diagnostic aids he/she deems appropriate to make a thorough diagnosis of my dental needs. I also authorize the doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I authorize and consent that the doctor employ any such assistance as he/she deems appropriate.

I, further authorize the release of any information, including the diagnosis, radiographs and records of any treatments or examinations rendered to my insurance company, consulting professionals or others that may request my records. I understand that I am personally responsible for payment of all fees for dental services provided in this office for me or my dependents, regardless of insurance coverage.

Breach of this responsibility carries the penalty of compensating the practice for any related fees. I understand that payment is due when services are rendered. Any other arrangements for payment must be made before treatment begins.

Patient, Parent or Guardian Signature: _____

Date: _____

JEFFREY J TIBBS, DDS, PA
3455 HEALY DRIVE
WINSTON-SALEM, NC 27103
336-765-7477

Communication Authorization for Release of Information

Jeffrey J. Tibbs, DDS, PA is authorized to release protected health information about the above patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions.

Entity to Receive Information

(check all that apply)

☐ Parent _____ (Full Name)

☐ Spouse _____ (Full Name)

☐ Other _____ (Name/Relationship)

☐ Voice Mail – Patient

☐ Answering Machine – Patient

Description of Information to be Released

(check all that apply)

☐ Results of tests/x-rays ☐ Appt. Information ☐ Billing/Financial Information

Rights of the Patient

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document by sending a written notification to Jeffrey J. Tibbs, DDS, PA.

I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward. I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditional on signing. This authorization shall be in effect until revoked by the patient.

Patient Signature _____ Date _____