Blue Ridge Orthodontics

Dustin Tipton D.D.S., M.S.
706-633-4824
Beautiful Smiles, Close to Home

Please complete, sign, and date both sides of this form.

Nickname: _____ Male: ☐ Female: ☐

Child's name: _____
first middle last

Address: _____
street city state zip

Phone: _____ Child's school: _____ Grade: _____
home

Birthdate: _____ Hobbies / Sports: _____

Whom may we thank for referring you? (Please circle one)
Family dentist internet newspaper Friend: _____

Parents marital status: ☐ married ☐ divorced ☐ single ☐ widowed

Father's Name: _____
first middle last

Email address: _____

Address Street: _____
street city state zip

Phone: _____
home cell work

Birthdate: _____ Social Security: _____ Father's Employer: _____

Primary Orthodontic Insurance: YES NO

Insurance Co. Name: _____ Insurance Co. Address: _____
Insurance Co. Phone: _____ Group #: _____ ID #: _____
Policy owners name: _____ Birthday: _____ Relationship to patient: _____
Policy owners employer: _____ Life time maximum $_____

Mother's Name: _____
first middle last

Email address: _____

Address Street: _____
street city state zip

Phone: _____
home cell work

Birthdate: _____ Social Security: _____ Mother's Employer: _____

Secondary Orthodontic Insurance: YES NO

Insurance Co. Name: _____ Insurance Co. Address: _____
Insurance Co. Phone: _____ Group #: _____ ID #: _____
Policy owners name: _____ Birthday: _____ Relationship to patient: _____
Policy owners employer: _____

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Health History

Please complete, sign, and date both sides of this form.

Patient's name: _____
first **middle** **last**

Family Dentist: _____ Clinic: _____

Last Check-up or cleaning within 6 months? YES NO

Family Physician: _____ Clinic: _____

Are you currently taking any prescription/ over-the counter drugs? YES NO

Please list each one: _____

Have you ever experienced any of the following problems?

Y N Headaches Y N Fainting
Y N Teeth Grinding Y N Vomiting
Y N Gagging Y N TMJ

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

Y N Latex
Y N Aspirin
Y N Ibuprofen
Y N Nickel

Other: _____

Diagnosed or Treated:

Y N Arthritis Y N Asthma
Y N Seizures Y N Hearing Impaired
Y N Head Trauma Y N Diabetes
Y N Anemia Y N Hepatitis
Y N Teeth Trauma Y N Pregnancy
Y N HIV/Aids Y N Blood Pressure
Y N** Joint Replacement/Implants
Y N** Rheumatic Fever
Y N** Heart murmur
*** Does the patient require antibiotic pre-

Insurance assignment and release-I, the undersigned assign directly to Tipton Orthodontics all insurance benefits, otherwise payable to me for services rendered. I also hereby authorize Tipton Orthodontics to release all information necessary to secure the payment of benefits. I authorize the use of the signature on all insurance submissions.

Financial Responsibility- I understand that I am financially responsible for all charges whether or not paid by insurance. I am aware of the financial policies regarding patient services, payment and insurance assignment if applicable.

In accordance with the federal government HIPAA rules, please sign below to acknowledge you have received our notice of Privacy Practices; it will in no way affect the care you receive at Tipton Orthodontics.

X _____ _____
Signature Date