Tipton Pediatric Dentistry 307 Carpenter Dam Road, Ste. G Hot Springs, AR 71901

NEW PATIENT REGISTRATION

PATIENT'S INFORMATION

Last Name	First Name	Middle Name	Preferred Name
Date of Birth	Age	Gender: ☐ male ☐ female	Social Security#
Mailing Address	City	State	Zip Code

Primary Contact# Primary Text# Secondary Contact #

Email Address

Primary Language Spoken Race/Nationality

How did you hear about us?

FAMILY INFORMATION

Name of Parent or Legal Guardian:	Relationship to patient:	Birth Date:
Address:	Contact#	
Name of Parent or Legal Guardian:	Relationship to patient:	Birth Date:
Address:	Contact#	

Who is financially responsible for the patient?

Are other family members seen by this office? ☐ No ☐ Yes (Include Below)

Name	Birth Date
Name	Birth Date

EMERGENCY CONTACT INFORMATION

Who should be notified in case of emergency? *(Not Living With You)*

Name	Phone	Relationship to Patient

PATIENT'S DENTAL HISTORY

Previous Dentist	Date of Last Exam

Any unhappy dental experiences? ☐ No ☐ Yes: Please explain.

Immediate Concerns:

ORAL HABITS *Check all that apply.*

○ Nail Biting	○ Mouth Breather	○ Pacifier Use	○ Sleeping with Bottle	○ Thumb Sucking

○ Other:

Patient Name: **Date of Birth:**

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PATIENT'S MEDICAL HISTORY

Primary Care Physician	Date of Last Exam

Ever been hospitalized? ☐**No** ☐**Yes** **Why/When?**

CURRENT MEDICATIONS:

ALLERGIES ☐ ***No Known Allergies*** ***Check all that apply:***

- ○ **Latex** ○ **Acrylic** ○ **Fish/Shrimp** ○ **Metal** ○ **Local Anesthetics**
- ○ **Pain Medications:** _____ ○ **Antibiotics:** _____
- ○ **Other Allergies:** _____

Has the patient ever had any history of or difficulty with any of the following?

○ ADD/ADHD	○ AIDS/HIV	○ Anemia	○ Asthma	○ Autism
○ Behavioral Disorder	○ Bladder Problems	○ Blood Disease	○ Cancer	○ Cerebral Palsy
○ Chicken Pox	○ Congenital Heart	○ Developmental Delay	○ Diabetes	○ Down Syndrome
○ Nicotine/Drug/Alcohol Abuse	○ Epilepsy	○ Fainting	○ Frequent Headaches	○ Head Injuries
○ Heart Disease	○ Heart Murmur	○ Hepatitis	○ High Blood Pressure	○ Kidney Disease
○ Liver Disease	○ Measles	○ Mental Disorders	○ Mononucleosis	○ Mumps
○ Nervous Disorders	○ Pregnancy	○ Radiation Treatment	○ Respiratory Problems	○ Rheumatic Fever
○ Seasonal Allergies	○ Seizures	○ Sensory Issues	○ Sickle Cell Trait	○ Active Sickle Cell
○ Sinus Problems	○ Speech Problems	○ Stomach Problems	○ Thyroid Disease	○ Tuberculosis
○ Tumors	○ Ulcers	○ Other		

If any conditions selected above need further clarification, please include that information below:

ACKNOWLEDGEMENT

The information I have given on the Patient Registration Form is correct to the best of my knowledge.

I understand that providing incorrect information can be dangerous to my child's health.

I understand that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my child's medical status.

Signature of Parent/Guardian_____**Date**_____

TIPTON PEDIATRIC DENTISTRY
Blayne Tipton, DDS Jordan Powell, DDS
307 CARPENTER DAM ROAD, STE. G HOT SPRINGS, ARKANSAS 71901
Office: 501-520-KIDS(5437) Fax: 501-520-5433

PERMISSION FORM

If you need someone other than the parent or legal guardian to bring your child, please fill in the information below before signing. **We are not** able to see your child in the absence of the parent or guardian unless the following is completed.

I, _____ (parent/legal guardian) give permission to:

_____	_____	_____
Name	Relationship to Patient	Phone Number
_____	_____	_____
Name	Relationship to Patient	Phone Number

to accompany my dependents listed below at dental appointments, sign consent for dental treatment or procedures, and schedule future appointments.

_____	_____
Name	Date of Birth
_____	_____
Name	Date of Birth
_____	_____
Name	Date of Birth
_____	_____
Name	Date of Birth

Parent/Guardian Signature **Date**

DENTAL INSURANCE INFORMATION

Please list all patients covered by the policy. This form must be completed if insurance is to be filed.

Patient Name	Birth Date	SS/Medicaid ID#
Patient Name	Birth Date	SS/Medicaid ID#
Patient Name	Birth Date	SS/Medicaid ID#
Patient Name	Birth Date	SS/Medicaid ID#

INSURANCE INFORMATION

PRIMARY COVERAGE		SECONDARY COVERAGE	
Subscriber's Name		Subscriber's Name	
Address		Address	
Primary Phone#		Primary Phone#	
Birth Date	Relationship to Patient	Birth Date	Relationship to Patient
Insurance Company		Insurance Company	
SS# / ID#		SS# / ID#	
Group#		Group#	
Employer		Employer	

Insurance plans are accepted after proper verification and approval from our office staff on the day of service if possible. If we accept your insurance, our office will file any claims to your insurance company as a courtesy to you. You will be responsible for any deductible and co-payment of total charges at the time of service. If your insurance plan has not paid the FULL BALANCE, and your claim does not require further verification from our office, you are required to pay the balance within 30 DAYS OF NOTIFICATION. If your insurance plan pays more than the balance due, we will refund you unless a credit on your account is requested.

I certify that the patient is covered by insurance and assign directly to Tipton Pediatric Dentistry. I understand that if I have dental insurance coverage that my claim will be submitted as a courtesy by Tipton Pediatric Dentistry. I also understand that I am responsible for any co-pays, deductibles or percentages that my insurance policy does not cover. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Authorized Person_____

Relationship to Patient_____ Date_____

TIPTON PEDIATRIC DENTISTRY

BLAYNE TIPTON, DDS & JORDAN POWELL DDS

307 Carpenter Dam Road, Suite G
Hot Springs, AR 71901
501-520-KIDS (5437)

TREATMENT CONSENT & INFORMATION RELEASE

Patient Name	Birth Date
Patient Name	Birth Date
Patient Name	Birth Date
Patient Name	Birth Date

I, being the parent or legal guardian of the above minor patient(s), hereby authorize and request the performance of dental services for this patient by the doctors and staff of Tipton Pediatric Dentistry.

I authorize Tipton Pediatric Dentistry to:

- Perform diagnostic procedures, treatment, and behavior management techniques that are reasonable, necessary and advisable.
- Administer anesthetics and/or analgesics that may be deemed advisable.
- Release any information concerning my child's treatment for the purpose of insurance benefits.
- Release any information concerning my child's treatment to another dentist or physician.
- Receive payment of insurance benefits otherwise payable to me.

I understand that:

- My dental insurance carrier or payer of my dental benefits may pay less that the actual bill for services, and that I am responsible for payment in full for all accounts.
- The treatment plan to be presented, along with the fees outlined could change depending upon the time elapsed since the initial examination and the extent of dental pathology.

FINANCIAL POLICY

Payment is due when services are rendered either by cash, check, credit card, and/or dental insurance. Assignment is accepted on dental insurance with the patient paying their estimated portion at the time of service. Any balance will be your responsibility. Any overpayment will be promptly reimbursed. Should it become necessary for Tipton Pediatric Dentistry to seek assistance in the collection of an outstanding bill, the responsible party will be held responsible for any collection agency fee, court cost and/or attorney fees that may be incurred as a result.

Signed _____ Date _____

Parent/Guardian

TIPTON PEDIATRIC DENTISTRY

BLAYNE TIPTON, D.D.S. & JORDAN POWELL, D.D.S.
307 Carpenter Dam Road, Suite G
Hot Springs, AR 71901
501-520-KIDS (5437)
fax: 501- 520-5433
tiptonpediatricdentistry@yahoo.com

RELEASE OF X-RAYS AND RECORDS AUTHORIZATION

I authorize release of dental x-rays and/or records of the patient(s) listed below to Tipton Pediatric Dentistry.

Please include records and x-rays for the following family members:

_____ DOB_____

_____ DOB_____

_____ DOB_____

_____ DOB_____

_____ _____
Name of Parent/Legal Guardian Requesting Information Date

_____
Parent/Guardian Signature

TIPTON PEDIATRIC DENTISTRY
307 Carpenter Dam Road, Suite G, Hot Springs, AR 71901
501-520-KIDS (5437)

Financial Policy/Consent for Payment

We are committed to providing the best possible care, and we are pleased to discuss our professional fees at any time. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy, or your responsibility.

FULL PAYMENT IS DUE AT THE TIME OF SERVICE

At the time of your initial visit, further treatment may be needed. If so, an appointment will be scheduled, and you may request an estimate for the needed treatment. We accept cash, check, Visa, MasterCard, Discover and American Express. We also offer third party financing through Care Credit. ALL FEES QUOTED ARE ESTIMATES AND ARE SUBJECT TO CHANGE DEPENDING ON THE NATURE OF TREATMENT NEEDED.

OUTSTANDING CHARGES/FEES

Should it become necessary for Tipton Pediatric Dentistry to seek assistance in the collection of an outstanding bill, you will be held responsible for any collection agency fee, court cost and/or attorney fees that may be incurred as a result.

CHECK POLICY

By using a check for payment, you agree to the following terms: In the event your check is dishonored or returned for any reason, you authorize us to electronically (or by paper draft) re-present the check to your bank account for collection of the amount of the check, plus any applicable fees as permitted by state law. A $25.00 fee will be assessed for any returned check.

MISSED APPOINTMENTS

Unless cancelled at least 24 hours in advance, you may be subject to a failed appointment charge of $25.00. Please help us serve you better by keeping your scheduled appointment.

I HAVE READ, UNDERSTAND AND AGREE TO TIPTON PEDIATRIC DENTISTRY'S FINANCIAL POLICIES.

Parent/Guardian Name _____

Parent/Guardian Signature _____ Date_____

Acknowledgement of Receipt of Notice of Privacy Practices

TIPTON PEDIATRIC DENTISTRY

* You May Refuse to Sign This Acknowledgment*

I understand that I may inspect or copy the protected health information described by this authorization.
I have been provided a copy of this office's Notice of Privacy Practices.
I understand that at any time, this authorization may be revoked when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed.
I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this acknowledgement.
I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

Print Name:_____

Signature:_____

Date:_____

For Office Use Only

_____

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

Tipton Pediatric Dentistry Cancelled and No-Show Appointment Policy

We at Tipton Pediatric Dentistry understand that you may at times need to cancel or reschedule an appointment due to emergencies or other unexpected issues. If you are unable to keep your appointment, please notify us at least 24 hours prior to your scheduled appointment time. You can reschedule or cancel appointments by calling or texting our clinic at 501-520-5437.

To ensure that each patient is given the proper amount of time allotted for their visit and to enable us to provide the highest quality care to everyone, it is very important for each scheduled patient to attend their visit on time. Late arrivals and unconfirmed appointments are subject to rescheduling or cancellation at the dentist's discretion. As a courtesy, we will attempt to provide an appointment reminder to you within 4 days of your scheduled appointment. However, it is your responsibility to arrive for your appointment on time, even if you do not receive a reminder.

Please Review The Following Policy:

1. Please notify the clinic at least 24 hours prior to your scheduled appointment should you need to change or cancel your reserved time. We keep a list of patients who need to be seen by our clinicians and, when possible, we offer cancelled appointments to patients on our waiting list to provide more timely care.
2. If less than a 24-hour notice is given, the cancellation will be documented as a "Cancelled" appointment.
3. If you do not present to the clinic for your appointment at the designated time, this will be documented as a "No-Show" appointment.
4. After the second "Cancelled" or "No-Show" appointment, you will receive a reminder of our "Cancelled/Missed Appointment" policy. Our clinic staff will help you reschedule this appointment if needed.
5. If you have 3 "Cancelled" or "No-Show" appointments within a 12-month time period or you have 3 consecutive "No-Show/Missed" appointments, you will receive notification from our clinic stating that your appointment records are under review and that you may not be able to schedule any future appointments and will be placed on our Same-Day Scheduling list.

As a patient of Tipton Pediatric Dentistry, please note that it is your responsibility to plan appointments accordingly and to notify the clinic promptly if you have difficulty keeping your scheduled appointment(s).

We appreciate your choosing Tipton Pediatric Dentistry and we look forward to providing excellent care to you!

I HAVE READ, UNDERSTAND AND AGREE TO TIPTON PEDIATRIC DENTISTRY'S CANCELLED AND NO-SHOW APPOINTMENT POLICIES.

Parent/Guardian Name _____

Parent/Guardian Signature _____ Date_____