



# Welcome

Thank you for trusting us with your health care. We promise to do our best to provide you with the finest care available. If you have any questions please do not hesitate to call us.

## Patient Information

Date \_\_\_\_\_ ID#/SS# \_\_\_\_\_

Patient \_\_\_\_\_

Address \_\_\_\_\_

Sex: ☐ M ☐ F Age \_\_\_\_\_ Birthdate \_\_\_\_\_

☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Occupation \_\_\_\_\_

Employer \_\_\_\_\_

Employer Address \_\_\_\_\_

Employer Phone (\_\_\_\_\_) \_\_\_\_\_

Spouse's Name \_\_\_\_\_

Birthdate \_\_\_\_\_ SS# \_\_\_\_\_

Occupation \_\_\_\_\_

Spouse's Employer \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

## Dental Insurance

Who is responsible for this account? \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Group # \_\_\_\_\_

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name \_\_\_\_\_

Birthdate \_\_\_\_\_ SS# \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Group # \_\_\_\_\_

### ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with \_\_\_\_\_ and assign directly to Dr. \_\_\_\_\_ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. 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.

\_\_\_\_\_  
Responsible Party Signature

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Date

## Patient Information

Home (\_\_\_\_\_) \_\_\_\_\_ Work (\_\_\_\_\_) \_\_\_\_\_ Ext. \_\_\_\_\_ Cell (\_\_\_\_\_) \_\_\_\_\_

Email (for appointment notification only) \_\_\_\_\_

### IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Home Phone (\_\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_\_) \_\_\_\_\_

## Dental History

Reason for today's visit _____	Blisters on lips or mouth <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to heat <input type="checkbox"/> Yes <input type="checkbox"/> No
Former Dentist _____	Cigarette, pipe, or cigar smoking <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to sweets <input type="checkbox"/> Yes <input type="checkbox"/> No
City/State _____	Clicking or popping jaw <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity when biting <input type="checkbox"/> Yes <input type="checkbox"/> No
Date of last dental visit _____	Dry mouth <input type="checkbox"/> Yes <input type="checkbox"/> No	Sores or growths in your mouth <input type="checkbox"/> Yes <input type="checkbox"/> No
Date of last dental X-rays _____	Grinding teeth <input type="checkbox"/> Yes <input type="checkbox"/> No	How often do you floss? _____
Place a mark on "yes" or "no" to indicate if you have had any of the following:	Gums swollen or tender <input type="checkbox"/> Yes <input type="checkbox"/> No	How often do you brush? _____
Bad Breath <input type="checkbox"/> Yes <input type="checkbox"/> No	Jaw pain or tiredness <input type="checkbox"/> Yes <input type="checkbox"/> No	
Bleeding Gums <input type="checkbox"/> Yes <input type="checkbox"/> No	Orthodontic Treatment <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Periodontal treatment <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Sensitivity to cold <input type="checkbox"/> Yes <input type="checkbox"/> No	

## Health History

Physician's Name \_\_\_\_\_ Date of last visit \_\_\_\_\_

Place a mark on "yes" or "no" to indicate if you have had any of the following:

AIDS/HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No	Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Radiation Treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Respiratory Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis, Rheumatism	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fainting or dizziness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Heart Valves	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Scarlet Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Joints	<input type="checkbox"/> Yes <input type="checkbox"/> No	Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shortness of Breath	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sinus Trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No
Back Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Skin Rash	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding abnormally, with extractions or surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis Type _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	Special Diet	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swollen Feet or Ankles	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemical Dependency	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaundice	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swollen Neck Glands	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemotherapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaw Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Circulatory Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tonsillitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Congenital Heart Lesions	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cortisone Treatments	<input type="checkbox"/> Yes <input type="checkbox"/> No	Low Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tumor or growth on head or neck	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cough, persistent or bloody	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mitral Valve Prolapse	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcer	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Nervous Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Veneral Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	Weight loss, unexplained	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Psychiatric Care	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Do you wear contact lenses? ☐ Yes ☐ No

Women:

Are you pregnant? ☐ Yes ☐ No

Taking birth control pills? ☐ Yes ☐ No

Due date \_\_\_\_\_ Are you nursing? ☐ Yes ☐ No

## Medications

List any medications you are currently taking and the correlating diagnosis:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Pharmacy Name \_\_\_\_\_

Phone (\_\_\_\_\_) \_\_\_\_\_

## Allergies

<input type="checkbox"/> Aspirin	<input type="checkbox"/> Local Anesthetic
<input type="checkbox"/> Barbiturates (Sleeping Pills)	<input type="checkbox"/> Penicillin
<input type="checkbox"/> Codeine	<input type="checkbox"/> Sulfa
<input type="checkbox"/> Iodine	<input type="checkbox"/> Other _____
<input type="checkbox"/> Latex _____	_____

## Acknowledgement of Receipt of Notice of Privacy Practices

I, \_\_\_\_\_ have received a copy of the Leslie H. Trippe D.D.S., Inc. Notice of Privacy Practices Form.  
(Name of Patient)

\_\_\_\_\_  
(Signature of Patient)

### Staff Will Fill Out This Section If Patient's Signature Not Obtained

Our office made a good faith effort to obtain Acknowledgment of Receipt of our Notice of Privacy Practices, but it was not obtained for the following reasons:

\_\_\_\_\_ Patient refused to sign.

\_\_\_\_\_ Emergency situation kept us from obtaining the patient's signature.

\_\_\_\_\_ Language barriers kept us from obtaining the patient's signature

\_\_\_\_\_ Other situation. \_\_\_\_\_

## **Acknowledgement of Financial Policy**

Welcome to Trippe Dental! As a courtesy to our patients, we will gladly file your insurance once your coverage has been confirmed. At the time of service, we will ask you to pay your estimated patient portion plus any deductible that may apply. Since we can only estimate what your insurance company will pay, you may be left with either a credit or a balance due. You can apply the credit to future dental care, or request a refund. Otherwise, a statement will be mailed if there is a balance due.

We accept cash, checks, Visa, MasterCard, Discover Card or Care Credit. A 5% discount is offered to those who want to pre-pay their entire treatment plan, payable only with cash or check. \*

If your account becomes delinquent, a 5% finance charge may be applied, per month to the past due balance. Delinquency is defined by 60 days past due. Any account that is sent to collections will receive a collection fee.

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Patients Signature

Date

**\*The 5% discount excludes Delta Dental members.**

**Trevor S. Winegar D.D.S.  
581 Pan American Dr, Suite 6  
Harker Heights, TX 76548**

**CONSENT RELATING TO TREATMENT OF MINOR PATIENT**

It is required by law that a parent or legal guardian accompanies their child under the age of 18 during their appointments unless written consent is given. Please fill out the consent form provided here, and send it with your child if they are coming by themselves or with someone other than their parent or legal guardian. Please include all current medications the child is taking, and all medical conditions.

I, \_\_\_\_\_ represent that I am the parent or legal guardian of \_\_\_\_\_, and hereby grant permission to Dr. Trevor Winegar and staff to perform dental procedures, including but not limited to x-rays, fillings, nitrous oxide (laughing gas), administration of anesthesia and any other services deemed advisable by the doctor even if am not present during the dental treatment.

All Medical Conditions/Medications Taken (use reverse side if necessary)

<b>Medical Condition</b>	<b>Medication(s)</b>
_____	_____
_____	_____
_____	_____
_____	_____

**Parent/Guardian Signature:**

\_\_\_\_\_

**Date:** \_\_\_\_\_