Tipton Lakes
Family Dentist
Dr. Christopher L. Bartels, DDS

Thank you for choosing Tipton Lakes Family Dentist for your dental needs. We look forward to meeting you in person at your first visit. We have included a Patient Registration and Medical History form. Please take the time to complete these forms prior to your visit.

Dr. Bartels is excited to be back home to open a family dental practice with **state-of-the-art** dental treatments and facilities. Tipton Lakes Family Dentist firmly believes in a long-term patient relationship to help smiles last a lifetime. He strives to be a family doctor providing patients with preventive, restorative, implant, and cosmetic care while embracing patient comfort first. Please visit our website to familiarize yourself with all of our offered services. www.TLDentist.com

Dr. Bartels and staff are looking forward to being a part of your dental family.

Sincerely,

Dr. Christopher L. Bartels, DDS

PATIENT REGISTRATION

Whom may we thank for referring you?_____

May appointments be scheduled by e-mail? Y N Add:_____
May appointment reminders be sent via text message? Y N #:_____

Patient name:_____
First M.I. Last
Preferred name:_____ Sex: ___M ___F

Address:_____
_____
Home Phone:_____ Date of birth:_____
Work Phone:_____ Soc. Sec._____
Cell Phone:_____ Drivers Lic._____

Marital Status: __Single __Married __Divorced __Widowed

Responsible Party (if other than patient)
Name:_____
First M.I. Last
Address (if different from patient):
_____
Home Phone:_____ Date of birth:_____
Work Phone:_____ Soc. Sec._____
Cell Phone:_____ Drivers Lic:_____

Insurance Information
Name of insured:_____ Relationship to patient:_____
Insured Soc. Sec._____ Insured birth date:_____
Employer:_____ Insurance Co:_____
Address:_____ Address:_____
_____ _____
Phone:_____ Phone:_____

Miscellaneous Information
Previous dentist:_____ Date of last dental visit:_____
Date of most recent dental x-rays: _____
Preferred pharmacy:_____
Emergency contact:_____ Contact #:_____

MEDICAL HISTORY

PATIENT NAME_____ BIRTH DATE_____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? Yes No If yes, please explain:_____
Have you ever been hospitalized or had a major operation? Yes No If yes, please explain: _____
_____
Have you ever had a serious head or neck injury? Yes No If yes, please explain: _____
_____
Are you taking any medications, pills, or drugs? Yes No If yes, please explain: _____
_____
Do you take, or have you taken Phen-Fen or Redux? Yes No _____
Are you on a special diet? Yes No _____
Do you use tobacco? Yes No _____
Do you use controlled substances? Yes No _____
Women: Are you: Pregnant/trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No

Are you allergic to any of the following:
___Aspirin ___Penicillin ___Codeine ___Acrylic ___Metal ___Latex ___Local anesthetics
___Other If yes, please explain:_____

Do you have, or have you had any of the following (please circle):

AIDS/HIV **+**	Cortisone Medicine	Hemophilia	Renal Dialysis
Alzheimer's Disease	Diabetes	Hepatitis A	Rheumatic Fever
Anaphylaxis	Drug Addiction	Hepatitis B or C	Rheumatism
Anemia	Easily Winded	Herpes	Scarlet Fever
Angina	Emphysema	High Blood Pressure	Shingles
Arthritis/Gout	Epilepsy or Seizures	Hives or Rash	Sickle Cell Disease
Artificial Heart Valve	Excessive Bleeding	Hypoglycemia	Sinus Trouble
Artificial Joint	Excessive Thirst	Irregular Heartbeat	Spina Bifida
Asthma	Fainting Spells/Dizziness	Kidney Problems	Stomach/Intestinal Disease
Blood Disease	Frequent Cough	Leukemia	Stroke
Blood Transfusion	Frequent Diarrhea	Liver Disease	Swelling of limbs
Breathing Problem	Frequent Headaches	Low Blood Pressure	Thyroid Disease
Bruise Easily	Genital Herpes	Lung Disease	Tonsilitis
Cancer	Glaucoma	Mitral Valve Prolapse	Tuberculosis
Chemotherapy	Hay Fever	Pain in Jaw Joints	Tumors or Growths
Chest Pains	Heart Attack/Failure	Parathyroid Disease	Ulcers
Cold sores/Fever blisters	Heart murmur	Psychiatric Care	Venereal Disease
Congenital Heart Disorder	Heart Pace Maker	Radiation Treatments	Yellow Jaundice
Convulsions	Heart Trouble/Disease	Recent Weight Loss	

Have you ever had any serious illness not listed above? Y N If yes, please explain:_____
_____

Additional comments:_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of patient, parent, or guardian_____

Date:_____

Financial Policy

PLEASE READ THE FOLLOWING CAREFULLY:

Thank you for choosing our office for your dental needs. We realize that every patient's financial situation is different. For this reason, we have worked hard to provide a variety of payment options to help you receive the dental care you need and deserve. We are always available to answer your questions or assist in any way we can. To maintain the practice operations and prevent any potential misunderstandings, we ask patients to accept and adhere to the following financial arrangements regarding their dental treatment.

Optional Payment terms:

1. **Full Pay Cash Discount:** We offer a 5% accounting courtesy for all treatment that is paid in full by cash or check when over $300 out-of-pocket.

2. **Major Service – Two Payment Option:** We offer a two-payment option for Crown, Bridge, and Denture treatment. We ask that you pay one-half of your co-payment at the first appointment and the second half at the seat date appointment.

3. **Credit Card Payment Option:** We allow (with a signed agreement form and ***established payment history*** with our office), a Credit Card Payment Option, which allows you to make three equal installments by credit card. One-third payment is due at the first appointment, one-third is due thirty days later, and the remaining one-third is due sixty days from the initial appointment. Our office personnel will charge these payments on your credit card on the due dates.

4. **Term Loan:** By arrangement with Care Credit, we offer our patients, upon approval, an interest-free term loan (up to 12 months) with no down payment, no annual fee, and no prepayment penalty. Please ask for an application.

We expect payment at the time service is rendered. If payment arrangements are needed, it must be made **PRIOR TO** your appointment. For patients with Dental Insurance, we do require payment of deductible and co-payment at the time of service. We allow 45 days from the date of submitting a claim to receive insurance payment. If payment has not been received, full balance of the account will then become the patient's responsibility. We accept cash, checks, debit cards, MasterCard, and Visa. There will be a **$20 charge on all returned checks**. When delinquent accounts are assigned to a collection agency or attorney, balance of the account and any associated collections fees will become the patient's or responsible party's responsibility.

Appointments: A specific amount of time is reserved especially for you. We strongly encourage all patients to keep their appointments. **We ask that you confirm your appointment within 48 hours of receiving your reminder**. If your appointment has not been confirmed we will appoint your time slot with another patient and reschedule your appointment for a future date. If you must change your appointment, *we require **at least** 48 hours notice to avoid a **$35/half-hour cancellation fee**.*

I acknowledge that I have received and understand the financial policies pertaining to my care at Tipton Lakes Family Dentist.

X_____