Larry W. Tilger, D.D.S., P.A.
938 Gemini
Houston, TX 77058

(281)480-6600

Patient Information

Chart #. _____
FOR OFFICE USE ONLY

Patient Name: _____ (Last) _____ (First) _____ (MI) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) Gender: ◯ Male ◯ Female Family Status: ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: _____ SS #. _____ Prev. Visit: _____

Email Address: _____ Best time to call: _____

Phone: _____ (Home) _____ (Work) _____ (Ext) _____ (Mobile) _____ (Fax) _____ (Other)

Address: _____ _____

_____ (City) _____ (State) _____ (Zip Code)

How did you hear about us?

- ◯ Website
- ◯ ZocDoc
- ◯ DemandForce
- ◯ Google Search
- ◯ Postcard
- ◯ Chamber Event
- ◯ Friend/Family Member - who may we thank for referring you?:_____

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Responsible Party Name

The following is for: ☐ the patient's spouse ☐ the person responsible for payment ☐ neither-not applicable

Name: _____ (Last) _____ (First) ____ (MI) _____ (Preferred Name)

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Phone: _____

Address: _____ _____

_____ (City) ____ (State) _____ (Zip Code)

Tilger Center for Dentistry appreciates the confidence you have placed in us to provide for your health care needs. The services you have elected to participate in implies a financial responsiblity on your part. The responsibility obligates you to ensure payment in full of our fees. If you have insurance, as a courtesy, we will verify your coverage and bill your insurance on your behalf. However, you are ultimately responsible for payment if the insurance company does not pay as estimated.

Signature: _____ Date: _____

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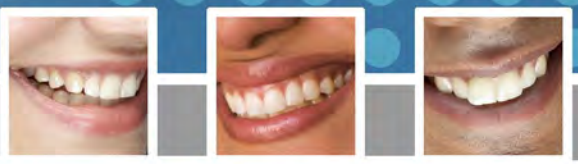

Primary Insurance

Name of Insured: _____ (Last) _____ (First) _____ (MI)

Insured's Birth Date: _____ ID #. _____ Group #. _____

Insured's Address: _____ _____

_____ (City) _____ (State) _____ (Zip Code)

Insured's Employer Name: _____

Employer Address: _____ _____

_____ (City) _____ (State) _____ (Zip Code)

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Insurance Address: _____ _____

_____ (City) _____ (State) _____ (Zip Code)

I certify that I, and/or my dependent(s) have insurance coverage. I authorize to assign benefits directly to Tilger Center for Dentistry for all insurance benefits payable for services rendered.

Tilger Center for Dentistry may use my healthcare information and may disclose such information to the above named insurance company(ies) and their agents for purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Signature: _____ Date: _____

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Secondary Insurance

Name of Insured: _____ (Last) _____ (First) _____ (MI)

Insured's Birth Date: _____ ID #. _____ Group #. _____

Insured's Address: _____

_____ City _____ State _____ Zip Code

Insured's Employer Name: _____

Employer Address: _____

_____ City _____ State _____ Zip Code

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Insurance Address: _____

_____ City _____ State _____ Zip Code

I certify that I, and/or my dependent(s) have insurance coverage. I authorize to assign benefits directly to Tilger Center for Dentistry for all insurance benefits payable for services rendered.

Tilger Center for Dentistry may use my healthcare information and may disclose such information to the above named insurance company(ies) and their agents for purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Signature: _____ Date: _____

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Health History

- [ ] Abnormal Bleeding
- [ ] AIDS/HIV
- [ ] Allergic to Asprin
- [ ] Allergic to Codeine
- [ ] Allergic to Iodine
- [ ] Allergic to Latex
- [ ] Allergic to PenVK
- [ ] Allergic to Sulfa
- [ ] Allergies
- [ ] Anemia
- [ ] Angina Pectoris
- [ ] Arthritis
- [ ] Artificial Joints
- [ ] Artificial Valve
- [ ] Asthma
- [ ] Blood Disease
- [ ] Blood Transfusion
- [ ] Cancer
- [ ] Chemotherapy
- [ ] Diabetes
- [ ] Dizziness
- [ ] Emphysema
- [ ] Epilepsy
- [ ] Excessive Bleeding
- [ ] Fainting
- [ ] Frequent Headache
- [ ] Glaucoma
- [ ] Growths
- [ ] H.I.V. Positive
- [ ] Hay Fever
- [ ] Head Injuries
- [ ] Heart Disease
- [ ] Heart Murmur
- [ ] Heart Surgery
- [ ] Hepatitis C
- [ ] Herpes
- [ ] High Blood Pressure
- [ ] Jaundice
- [ ] Jaw Pain
- [ ] Kidney Disease
- [ ] Liver Disease
- [ ] Low Blood Pressure
- [ ] Mental Disorders
- [ ] MitralValve Prolapse
- [ ] Nervous Disorders
- [ ] Other
- [ ] Pacemaker
- [ ] Persistant cough
- [ ] Pre- Medication
- [ ] Pregnancy
- [ ] Radiation Treatment
- [ ] Respiratory Problems
- [ ] Rheumatic Fever
- [ ] Rheumatism
- [ ] Shortness of Breath
- [ ] Sinus Problems
- [ ] Stomach Problems
- [ ] Stroke
- [ ] Thyroid Problem
- [ ] Tonsilitis
- [ ] Tuberculosis
- [ ] Tumors
- [ ] Ulcers
- [ ] Venereal Disease

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Medications (please include supplements and over the counter):

Reason for your visit today:

Date of last dental cleaning and dentist name

Mark all that apply:

- ☐ Bad Breath
- ☐ Gums (circle all that apply) Swollen Tender Bleeding
- ☐ Blisters or Sores on Lip or Mouth
- ☐ Burning Sensation on Tongue
- ☐ Tobacco Use (circle all that apply) Cigarette Cigar Chewing
- ☐ Jaw (circle all that apply) Pain Discomfort Clicking Popping Grinding
- ☐ Dry Mouth
- ☐ Food Collecting Between Teeth
- ☐ Loose Teeth or Broken Fillings
- ☐ Orthodontic Appliance
- ☐ Pain Around Ear
- ☐ Previous Periodontal Treatment or "Deep Cleaning"
- ☐ Sensitive to-- (circle all that apply) Hot Cold Sweets Biting

How often do you floss?_____ How often do you brush?_____

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HIPAA PATIENT CONSENT

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent. The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date. You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations. By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:
*Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
*The practice reserves the right to change the privacy policy as allowed by law.
*The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
*The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
*The practice may condition receipt of treatment upon execution of this consent.

May we discuss your medical condition with any member of your family?

◯ Yes ◯ No

May we leave a message on your answering machine at home or on your cell phone?

◯ Yes ◯ No

May we phone, email, or send a text to you to confirm appointments?

◯ Yes ◯ No

If YES, please name the members allowed:

Signature: _____ Date: _____

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Office Policy

Thank you for choosing Tilger Center for Dentistry to provide your dental care, we consider it an honor to have been chosen by you to do so. Our philosophy in serving people is to be informative, honest and forthright. All treatment is performed with the patient's entire health in mind and is geared toward each patient's individual needs. Our office desires to make each patient's visit as comfortable and as educational as possible.

Insurance:

. We estimate insurance payments and file insurance claims as a courtesy to our patients.
. We are not responsible for any decisions made by the insurance company.
. Ultimately the amount covered by the insurance is an estimate and that patient is responsible for all costs of the dental services.

Treatment Plans:

. These provide an ESTIMATE of what insurance will pay.
. The services needed may change over time or, once treatment has begun, an alternate procedure may be deemed necessary.
. The patient will be informed before any treatment is performed and the patient will be responsible for the cost for the treatment provided.
. Payment is required at the time that treatment is provided.

Appointments:

. If you are more than 15 minutes past your appointment time, you may not be seen for all of your scheduled services and you may be required to schedule another appointment.
. If a patient cancels within 24 hours (appointments reserved for an hour or less) to 72 hours (appointments reserved for longer than an hour) of their appointment or misses the appointment, a cancellation charge will be billed to the patient.
. If appointment cancellations occur on several occasions, we reserve the right to only schedule on the same day or not at all.
. If an appointment cannot be verbally confirmed by the patient, the appointment cannot be guaranteed to the patient and the appointment m

Signature: _____ Date: _____

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Response Date: