PATIENT REGISTRATION

PATIENT INFORMATION

First Name:________________ Middle Initial:______ Last Name:________________

Preferred Name:________________ Date of Birth:________________ Sex: ❍ Male ❍ Female

Address:____
Street City State Zip

Home Phone:________________ Cell Phone:________________ Work Phone:________________

Email:________________________________ SSN#:________________

MARITAL STATUS: ❍ Married ❍ Single ❍ Divorced ❍ Separated ❍ Widowed

EMPLOYMENT STATUS: ❍ Full-time ❍ Part-time ❍ Retired ❍ Full-time Student ❍ Part-time Student

How did you hear about our practice (friend, family, internet search, etc.)? ________________________________

____

RESPONSIBLE PARTY (If someone other than the patient)

First Name:________________ Middle Initial:______ Last Name:________________

Date of Birth:________________ SSN#:________________

Please disregard next questions if same as above:

Address:____
Street City State Zip

Home Phone: ________________ Cell Phone: ________________ Work Phone:________________

Email Address: ________________________________

❍ Responsible Party is also a Policy Holder for Patient ❍ Primary Insurance Policy Holder ❍ Secondary Insurance Policy Holder

PRIMARY INSURANCE INFORMATION

Name of Policyholder: ________________

Relationship to Policyholder: ❍ Self ❍ Spouse ❍ Child ❍ Other

Policyholder's SSN: ________________

Policyholder's Date of Birth: ________________

Employer: ________________

Insurance Company:________________

Member ID Number: ________________

Plan/Group Number: ________________

SECONDARY INSURANCE INFORMATION

Name of Policyholder: ________________

Relationship to Policyholder: ❍ Self ❍ Spouse ❍ Child ❍ Other

Policyholder's SSN: ________________

Policyholder's Date of Birth: ________________

Employer: ________________

Insurance Company:________________

Member ID Number: ________________

Plan/Group Number: ________________

HIPAA PATIENT PRIVACY INFORMATION

Patient's Name: ______________________________ Date of Birth: ______________________________

RELEASE OF MEDICAL/DENTAL INFORMATION

I give my permission to release confidential health information to the following people:

Name: ______________________________ Relationship: ______________________________

Name: ______________________________ Relationship: ______________________________

Name: ______________________________ Relationship: ______________________________

***Please specify if there is any personal health information you DO NOT want to be disclosed to the above named people: ______________________________

____

____

TELEPHONE CONTACT

Please read the following choices and tell us whether or not we may leave messages regarding your medical/dental information and with whom we may leave it with.

Primary phone number (including area code): ______________________________

- May we call you at this number? ❍ Yes ❍ No
- May we leave a message on your voicemail asking to return our call? ❍ Yes ❍ No
- May we leave a message on your voicemail regarding your dental care? ❍ Yes ❍ No
- May we leave a message to return our call with the person answering the phone ? ❍ Yes ❍ No

Secondary phone number (including area code): ______________________________

- May we call you at this number? ❍ Yes ❍ No
- May we leave a message on your voicemail asking to return our call? ❍ Yes ❍ No
- May we leave a message on your voicemail regarding your dental care? ❍ Yes ❍ No
- May we leave a message to return our call with the person answering the phone ? ❍ Yes ❍ No

Alternate phone number (including area code): ______________________________

- May we call you at this number? ❍ Yes ❍ No
- May we leave a message on your voicemail asking to return our call? ❍ Yes ❍ No
- May we leave a message to return our call with the person answering the phone ? ❍ Yes ❍ No

Additional notes or comments: ______________________________

____

Patient/Guardian Signature: ______________________________ Date: ______________________________

Please notify this office in writing of your request to change or update any of the above information.

HIPAA PRIVACY COMPLIANCE

NOTICE OF PRIVACY PRACTICES

As our patient, a copy of the Newman Family Dentistry Privacy Practices policy will be available at any time from our reception desk or directly from our practice office. This information can be shared with you at any time upon request.

COMPLAINTS/COMMENTS

If you have any complaints concerning our privacy practices, you may contact Holly Walton at (317) 293-3000 (NewmanFamilyDentistry.com).

YOU WILL NOT BE RETALIATED AGAINST OR PENALIZED BY US FOR FILING A COMPLAINT.

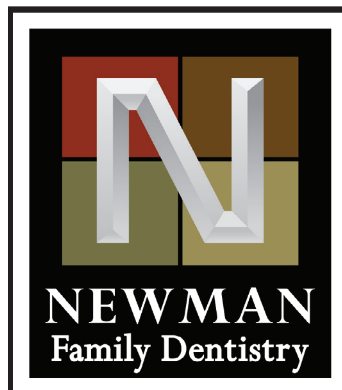
SIGNATURE REQUIRED

Your signature is required below indicating that the entirety of Newman Family Dentistry Privacy Practices Policy has been shared with you. By signing, you also acknowledge that an actual copy of this policy as been offered to you as well. This signature page will be maintained in your records and a copy will be provided to you upon request.

Patient/Guardian Signature: ______________________________

Patient/Guardian Name – Printed: ______________________________

Date: ______________________________



Revised 5-8-2014

FINANCIAL RESPONSIBILITY

FINANCIAL RESPONSIBILITY AGREEMENT

Our credit policies have been established to ensure that the best services can be provided to you and your family and any misunderstandings can be avoided.

Our professional services are rendered to the patient and not to the insurance company. The insurance company is responsible to the patient and the patient is responsible to the doctor. You are responsible for the payment of any and all bills not covered by or paid for by your insurance company.

For your convenience, our office has made arrangements with **Care Credit** to offer low monthly payments with fixed or no interest fee plans. Ask our front office staff for assistance applying.

We believe our fees give an excellent value for the high quality and variety of services we provide. That said, please remember that what insurance companies call "Usual and Customary Fees" can vary widely with the dental plans offered by your employer and by which plan the employee selects.

PAYMENT IS DUE AND PAYABLE AS SERVICES ARE RENDERED

(Please indicate the manner in which you wish to handle payment on your account.)

_____________ 1. I do not have insurance and I agree that I am responsible for payment in full on the date of service/treatment by check, cash, credit card, debit card or Care Credit. Patients without insurance will receive a 15% courtesy discount off services only.

_____________ 2. I have insurance and I agree that I am responsible for payment in full of my estimated portion the day of service/treatment by check, cash, credit card, debit card or Care Credit.

TREATMENT PLANS: All treatment plans given by Newman Family Dentistry are an ESTIMATE only. If you want a guaranteed price, we can submit a pre-determination to your insurance company.

INTEREST: We reserve the right to charge interest in the amount of 1.5% per month as provided by state law, or a billing fee of $12.50 on accounts 30 days or older.

CANCELLATION AND FAILED POLICY NOTICE: Due to an increase in demand for appointments, and to help better serve all our patients, we have implemented a "Cancellation and Failed Appointment Policy." Effective immediately, all cancellations require a 24 HOUR NOTICE. If we are not given proper notice, there will be a $35.00 charge added to your account. A failed appointment (a missed appointment without any notice) will result in a $50.00 charge added to your account.

In consideration of treatment required, I accept full financial responsibility. Insurance forms will be completed as a courtesy to the patient; however, your estimated payment not covered by insurance is expected on the date of services/treatment rendered unless prior arrangements are made. I further agree that if this account is turned over to an attorney or collection agency, I will be responsible for all collection fees, attorney fees, and interest and court costs. I also agree to assign any and all insurance benefits to be paid directly to Don M. Newman, D.D.S., P.C. (Newman Family Dentistry).

I HAVE READ THIS FINANCIAL AGREEMENT. I UNDERSTAND AND AGREE TO THIS FINANCIAL AGREEMENT

Patient or Responsible Party Signature:______________________________ Date: ____________________

Revised 1-2020

PATIENT MEDICAL HISTORY

PATIENT NAME:____________________________ **DATE OF BIRTH:**________________

Are you under a physician's care now or have you been recently hospitalized? ❍ Yes ❍ No If yes, please specify: ____________________

If you answered yes to the previous question, please provide your doctor's name(s) and contact information:

____

Do you take any medications, supplements or vitamins? If so, please list: ____________________

____

Have you had a knee, hip or any type of joint replacement surgery? ❍ Yes ❍ No If yes, specify area, when and doctor:____________________

Are you required to take an antibiotic pre-medication prior to any dental procedure? (If unsure, leave blank.) ❍ Yes ❍ No

Do you use aspirin, antiplatelet or anticoagulant drugs (blood thinners)? ❍ Yes ❍ No

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ❍ Yes ❍ No

Do you use tobacco or vaping products? ❍ Yes ❍ No If yes, please specify which: ____________________

Have you ever been prescribed pain killers (opioids) for chronic pain? ❍ Yes ❍ No

Have you been diagnosed with snoring or obstructive sleep apnea? ❍ Yes ❍ No If yes, do you use a CPAP machine? ❍ Yes ❍ No

Do you have any special needs that may require additional help during your visit? ❍ Yes ❍ No If yes, please specify: ____________________

____

WOMEN ONLY: Please indicate if you are ❍ Pregnant ❍ Nursing

Are you allergic to any of the following?

Penicillin	❍	Latex	❍	Codeine	❍	Metal	❍
Sulfa Drugs	❍	Keflex (Cephalexin)	❍	Adverse Reaction to Local Anesthetics	❍	Hydrocodone (Norco)	❍

Do you have allergies to medications and/or materials not listed? ❍ Yes ❍ No If yes:____________________

Do you have, or have you had, any of the following?

Heart disease	❍ Yes ❍ No	Blood transfusion	❍ Yes ❍ No	Epilepsy or seizures	❍ Yes ❍ No	Cancer	❍ Yes ❍ No
High blood pressure	❍ Yes ❍ No	Leukemia	❍ Yes ❍ No	Stroke	❍ Yes ❍ No	Tumor or growths	❍ Yes ❍ No
Low blood pressure	❍ Yes ❍ No	Bruise easily	❍ Yes ❍ No	Hay fever	❍ Yes ❍ No	Radiation treatment	❍ Yes ❍ No
High cholesterol	❍ Yes ❍ No	Stomach ulcers	❍ Yes ❍ No	Scarlet fever	❍ Yes ❍ No	Chemotherapy	❍ Yes ❍ No
Artificial heart valve	❍ Yes ❍ No	Kidney problems	❍ Yes ❍ No	Rheumatic fever	❍ Yes ❍ No	Tuberculosis	❍ Yes ❍ No
Irregular heart beat	❍ Yes ❍ No	Dialysis	❍ Yes ❍ No	Cold sores	❍ Yes ❍ No	HIV positive	❍ Yes ❍ No
Fainting spells	❍ Yes ❍ No	Glaucoma	❍ Yes ❍ No	Excessive thirst	❍ Yes ❍ No	Drug addiction	❍ Yes ❍ No
Mitral valve prolapse	❍ Yes ❍ No	Sinus problems	❍ Yes ❍ No	Diabetes	❍ Yes ❍ No	Genital herpes	❍ Yes ❍ No
Congenital heart condition	❍ Yes ❍ No	Tonsilitis	❍ Yes ❍ No	Hypoglycemia	❍ Yes ❍ No	Hives or rash	❍ Yes ❍ No
Chest pains/angina	❍ Yes ❍ No	Easily winded	❍ Yes ❍ No	Hepatitis	❍ Yes ❍ No	Shingles	❍ Yes ❍ No
Heart attack	❍ Yes ❍ No	Emphysema/COPD	❍ Yes ❍ No	Liver disease	❍ Yes ❍ No	Psoriasis	❍ Yes ❍ No
Pacemaker	❍ Yes ❍ No	Asthma	❍ Yes ❍ No	Thyroid disease	❍ Yes ❍ No	Psychiatric care	❍ Yes ❍ No
Heart murmur	❍ Yes ❍ No	Alzheimer's disease	❍ Yes ❍ No	Parathyroid disease	❍ Yes ❍ No	Anxiety/depression	❍ Yes ❍ No
Hemophilia	❍ Yes ❍ No	Parkinson's disease	❍ Yes ❍ No	Pain in jaw joints	❍ Yes ❍ No	Sensory processing issues	❍ Yes ❍ No
Anemia	❍ Yes ❍ No	Multiple Sclerosis	❍ Yes ❍ No	Artificial joint(s)	❍ Yes ❍ No	ADD/ADHD	❍ Yes ❍ No
Excessive bleeding	❍ Yes ❍ No	Frequent headaches	❍ Yes ❍ No	Arthritis/Rheumatism	❍ Yes ❍ No		
Sickle cell disease	❍ Yes ❍ No	Autism	❍ Yes ❍ No	Osteoporosis	❍ Yes ❍ No		

Have you ever had any serious illness not listed above? If so, please explain: ____________________

____

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 responsiblity to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X____________________________ Date:____________________

NEW PATIENT QUESTIONNAIRE

Patient Name:_______________________________________ Today's Date:_______________________

How did you hear about our office (friend, family, internet search, insurance directory, etc.)? _______________________

What brings you in today? ____

____

When was your last dental visit: ❍ Less than one year ❍ 1-2 Years ❍ 2-5 Years ❍ 5+ Years

Reason: ____

When was your last dental cleaning? ❍ Less than one year ❍ 1-2 Years ❍ 2-5 Years ❍ 5+ Years

Have you ever had an unpleasant dental experience? ❍ Yes ❍ No

If yes, please explain: ____

Please tell us how we can help to make your experience more pleasant: _______________________

____

Do you have tooth pain, discomfort or sensitivity? ❍ Yes ❍ No

If yes, please explain: ____

Have you had orthodontic treatment (braces)? ❍ Yes ❍ No

Are you interested in straighter teeth? ❍ Yes ❍ No

Do you wear an appliance? (i.e. nightguard or retainer)? ❍ Yes ❍ No If yes, please specify: _______________________

Do you grind your teeth, clench and/or have muscle soreness? ❍ Yes ❍ No ❍ Unsure

Would you like whiter teeth? ❍ Yes ❍ No

Are you satisfied with your smile? ❍ Yes ❍ No

If not, what would you like to change?____

Do you have dental fear or anxiety? ❍ Yes ❍ No

If yes, would you be interested in knowing more about conscious sedation? ❍ Yes ❍ No

What is your occupation? ____

We want to know about you! Do you have any hobbies or interests? _______________________

____