NEWMAN
Family Dentistry

PATIENT REGISTRATION

PATIENT INFORMATION

First Name: _____ Middle Initial: _____ Last Name: _____

Preferred Name: _____ Email*: _____

Address: _____
Street City State Zip

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Date of Birth: _____ SSN#: _____ Driver's License # & State of Issue: _____

SEX: ❍ Male ❍ Female MARITAL STATUS: ❍ Married ❍ Single ❍ Divorced ❍ Separated ❍ Widowed

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

***Check if you would like to receive correspondence from us via email. ❍**

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: _____

Address: _____
Street City State Zip

Home Phone: _____ Cellular Phone: _____

Work Phone: _____ Ext: _____ Email: _____

Date of Birth: _____ SSN#: _____ Driver's License # & State of Issue: _____

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

PRIMARY INSURANCE INFORMATION

Name of Insured: _____

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

Insured SSN: _____

Insured Date of Birth: _____

Employer: _____

Employer Address: _____

_____

Insurance Company: _____

Insurance Company Address: _____

_____

SECONDARY INSURANCE INFORMATION

Name of Insured: _____

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

Insured SSN: _____

Insured Date of Birth: _____

Employer: _____

Employer Address: _____

_____

Insurance Company: _____

Insurance Company Address: _____

_____

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NEW PATIENT QUESTIONNAIRE

Patient Name:_____ Today's Date:_____

How did you hear about our office? _____

What brings you in today? _____

Date of 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 had an unpleasant dental experience in the past? ❍ Yes ❍ No

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 snore or have been diagnosed with sleep apnea? ❍ Yes ❍ No
Comments: _____

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? _____

_____

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PATIENT MEDICAL HISTORY

Patient Name:_____ Date of Birth:_____

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 dental treatment 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 If yes, please explain: _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing biophosphonates? ❍ Yes ❍ No If yes, please explain: _____
Are you on a special diet? ❍ Yes ❍ No If yes, please explain: _____
Do you use controlled substances? ❍ Yes ❍ No If yes, please explain: _____
Do you use tobacco? ❍ Yes ❍ No

FOR WOMEN ONLY:

Are you pregnant or trying to get pregnant? ❍ Yes ❍ No Are you nursing? ❍ Yes ❍ No Do you take oral contraceptives? ❍ Yes ❍ No

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

❍ Aspirin ❍ Penicillin ❍ Codeine ❍ Acrylic ❍ Metal ❍ Latex/Rubber ❍ Local Anesthetics ❍ Sulfa Drugs ❍ Other: _____

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

AIDS/HIV Positive ❍ Yes ❍ No	Diabetes ❍ Yes ❍ No	Hepatitis A ❍ Yes ❍ No	Renal Dialysis ❍ Yes ❍ No
Alzheimer's Disease ❍ Yes ❍ No	Drug Addiction ❍ Yes ❍ No	Hepatitis B or C ❍ Yes ❍ No	Rheumatic Fever ❍ Yes ❍ No
Anaphylaxis ❍ Yes ❍ No	Easily Winded ❍ Yes ❍ No	Herpes ❍ Yes ❍ No	Rheumatism ❍ Yes ❍ No
Anemia ❍ Yes ❍ No	Emphysema ❍ Yes ❍ No	High Blood Pressure ❍ Yes ❍ No	Scarlet Fever ❍ Yes ❍ No
Angina ❍ Yes ❍ No	Epilepsy or Seizures ❍ Yes ❍ No	High Cholesterol ❍ Yes ❍ No	Shingles ❍ Yes ❍ No
Arthritis/Gout ❍ Yes ❍ No	Excessive Bleeding ❍ Yes ❍ No	Hives or Rash ❍ Yes ❍ No	Sickle Cell Disease ❍ Yes ❍ No
Artificial Heart Valve ❍ Yes ❍ No	Excessive Thirst ❍ Yes ❍ No	Hypoglycemia ❍ Yes ❍ No	Sinus Trouble ❍ Yes ❍ No
Artificial Joint ❍ Yes ❍ No	Fainting Spells/Dizziness ❍ Yes ❍ No	Irregular Heartbeat ❍ Yes ❍ No	Spina Bifida ❍ Yes ❍ No
Asthma ❍ Yes ❍ No	Frequent Cough ❍ Yes ❍ No	Kidney Problems ❍ Yes ❍ No	Stomach/Intestinal Disease ❍ Yes ❍ No
Blood Disease ❍ Yes ❍ No	Frequent Diarrhea ❍ Yes ❍ No	Leukemia ❍ Yes ❍ No	Stroke ❍ Yes ❍ No
Blood Transfusion ❍ Yes ❍ No	Frequent Headaches ❍ Yes ❍ No	Low Blood Pressure ❍ Yes ❍ No	Swelling of Limbs ❍ Yes ❍ No
Breathing Problems ❍ Yes ❍ No	Genital Herpes ❍ Yes ❍ No	Lung Disease ❍ Yes ❍ No	Thyroid Disease ❍ Yes ❍ No
Bruise Easily ❍ Yes ❍ No	Glaucoma ❍ Yes ❍ No	Mitral Valve Prolapse ❍ Yes ❍ No	Tonsillitis ❍ Yes ❍ No
Cancer ❍ Yes ❍ No	Hay Fever ❍ Yes ❍ No	Osteoporosis ❍ Yes ❍ No	Tuberculosis ❍ Yes ❍ No
Chemotherapy ❍ Yes ❍ No	Heart Attack/Failure ❍ Yes ❍ No	Pain in Jaw Joints ❍ Yes ❍ No	Tumors or Growths ❍ Yes ❍ No
Cold Sores/Fever Blisters ❍ Yes ❍ No	Heart Murmur ❍ Yes ❍ No	Parathyroid Disease ❍ Yes ❍ No	Ulcers ❍ Yes ❍ No
Congenital Heart Disorder ❍ Yes ❍ No	Heart Pacemaker ❍ Yes ❍ No	Psychiatric Care ❍ Yes ❍ No	Venereal Disease ❍ Yes ❍ No
Convulsions ❍ Yes ❍ No	Heart Trouble/Disease ❍ Yes ❍ No	Radiation Treatments ❍ Yes ❍ No	Yellow Jaundice ❍ Yes ❍ No
Cortisone Medicine ❍ Yes ❍ No	Hemophilia ❍ Yes ❍ No	Recent Weight Loss ❍ Yes ❍ No	

Have you ever had any serious illness not listed? ❍ Yes ❍ No

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:_____ Date:_____

NEWMAN Family Dentistry

THIS QUESTIONNAIRE IS FOR AGE 18 YEARS AND OVER

PERIODONTAL RISK ASSESSMENT

Patient Name:_____ Today's Date:_____

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

		Amount Per Day?	Used for How Many Years?	If You Quit, List What Year
Cigarette Smoking	❍ Yes ❍ No	_____	_____	_____
Cigar Smoking	❍ Yes ❍ No	_____	_____	_____
Pipe Smoking	❍ Yes ❍ No	_____	_____	_____
Chewing Tobacco	❍ Yes ❍ No	_____	_____	_____

Do you have diabetes? ❍ Yes ❍ No

If yes,
- Is your diabetes under control? ❍ Yes ❍ No
- Are you prone to diabetic complications? ❍ Yes ❍ No

Do you have a family history of diabetes? ❍ Yes ❍ No

Have you had any of these warning signs of diabetes?
- Frequent urination/excessive thirst ❍ Yes ❍ No
- Excessive hunger ❍ Yes ❍ No
- Slow healing of cuts ❍ Yes ❍ No
- Weakness/fatigue ❍ Yes ❍ No
- Unexplained weight loss ❍ Yes ❍ No

Who is your physician for diabetes? _____

Physician phone:_____

Do you have any of the following risk factors for heart disease or stroke?
- Family history of heart disease ❍ Yes ❍ No
- High cholesterol ❍ Yes ❍ No
- Tobacco use ❍ Yes ❍ No
- High blood pressure ❍ Yes ❍ No
- Obesity ❍ Yes ❍ No

If you have any of these risk factors, it is especially important for you to always keep your gums as healthy as possible!

Do you have a heart murmur or artificial joint? ❍ Yes ❍ No
If yes, does your Dr. recommend antibiotics prior to dental visits? ❍ Yes ❍ No

Do you have an immediate family member(s) who currently has or has had gum problems in the past? ❍ Yes ❍ No

If you answered yes, it is especially important to always keep your gums as healthy and inflammation-free as possible to reduce the chance of bacterial infection originating from the mouth.

Are you currently taking, or have you taken, any of the following medications?

ANTI-SEIZURE MEDICATIONS:
(Dilantin®, Tegretol®, Phenobarbital, etc.) ❍ Yes ❍ No
If you answered yes, are you still taking the medication? ❍ Yes ❍ No
If yes, which medication?_____

CALCIUM CHANNEL BLOCKER BLOOD PRESSURE MEDICATIONS:
(Procardia®, Cardizem®, Norvasc®, Verapamil®, etc.) ❍ Yes ❍ No
If you answered yes, are you still taking the medication? ❍ Yes ❍ No
If yes, which medication?_____

IMMUNOSUPPRESSANT THERAPY MEDICATIONS:
(Predinisone, Azathioprine, Cyclosporings, Corticosteriods [Asthma Inhaler],etc.) ❍ Yes ❍ No
If yes, which medication?_____

ESTROGEN REPLACEMENT THERAPY/HORMONE REPLACEMENT THERAPY MEDICATIONS:
(Prempro®, Premarin®, Premphase®, Fosamax®, Actonel®, Evista®, Fortéo®, etc.) ❍ Yes ❍ No
If yes, which medication?_____

_____

Are you under a lot of stress? ❍ Yes ❍ No
Do you find it difficult to maintain a well-balanced diet? ❍ Yes ❍ No

The following are signs of gum disease. Please check all that apply:
- Persistent bad breath ❍ Yes ❍ No
- Pus between the teeth and gums ❍ Yes ❍ No
- Red, swollen or tender gums ❍ Yes ❍ No
- Loose or separating teeth ❍ Yes ❍ No
- Food catching between teeth ❍ Yes ❍ No
- Change in the way your teeth bite together ❍ Yes ❍ No
- Bleeding gums during tooth brushing or flossing ❍ Yes ❍ No
- Gums that have pulled away from teeth ❍ Yes ❍ No
- Teeth that keep you from eating specific foods ❍ Yes ❍ No

Is it important to you to keep your teeth as long as possible? ❍ Yes ❍ No
Do you like the appearance of your smile? ❍ Yes ❍ No
Do you like the color of your teeth? ❍ Yes ❍ No

If you have missing teeth, why have you not had them replaced?_____

_____

The following can adversely affect your gums. Please check all that apply:
- Pregnant ❍ Yes ❍ No
- Nursing ❍ Yes ❍ No
- Menopause ❍ Yes ❍ No
- Taking birth control pills ❍ Yes ❍ No

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: _____

_____

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 Signature: _____

Patient Name – Printed: _____

Date: _____

Revised 5-8-2014

NEWMAN
Family Dentistry

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 will pay 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 to pay 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: _____