NEWMAN
Family Dentistry

PATIENT REGISTRATION

PATIENT INFORMATION

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

Preferred Name:_____ SEX: ❍ Male ❍ Female

Date of Birth:_____ SSN#:_____

Address:_____
Street City State Zip

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

Email Address:_____

RESPONSIBLE PARTY (If someone other than the patient)

Relationship to 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:_____

DENTAL 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 DENTAL INSURANCE

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:_____

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HIPAA PATIENT PRIVACY INFORMATION

Patient's Name: _____ Date of Birth: _____

RELEASE OF MEDICAL/DENTAL INFORMATION

Please list any persons that you would like to have access to your health information. For minors, please include any family members that may be possibly taking your child to their dental visits in the future (i.e. grandparents, relatives, etc).

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Patient/Guardian Name-Printed: _____ Date: _____

Patient/Guardian Signature: _____

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

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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 Ashley 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 Name-Printed: _____ Date: _____

Patient/Guardian Signature: _____

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Revised 8-2025

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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.

FOR NON-MEDICAID PATIENTS, PAYMENT OF $545 IS DUE AND PAYABLE AS SERVICES ARE RENDERED. FOR CASES THAT REQUIRE ORAL SEDATION OR NITROUS OXIDE, AN ADDITIONAL FEE OF $75 WILL BE APPLIED. A FRENULOPLASTY PROCEDURE MAY BE DONE FOR ADULTS AND OLDER CHILDREN AND THE FEE IS $645 DUE ON THE DATE OF SERVICE.

DENTAL INSURANCE CLAIMS: All dental insurance claims will be filed by our office. Your insurance company will send you an Explanation of Benefits (EOB) once the claim has been paid. Policy holders typically receive the EOB notice before we do. Once we receive the EOB, we will be able to determine if a refund is needed. In some cases, the patient may have an additional balance owed as determined by the policy holder's plan. Refunds may take anywhere from 6-8 weeks to distribute.

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: 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." All cancellations require a 24 HOUR NOTICE. If we are not given proper notice, there will be a $75.00 charge added to your account. A failed appointment (a missed appointment without any notice) will result in a $75.00 charge added to your account. Patients that have multiple cancelled and/or failed appointments will require a $75 reservation fee for all future visits. The reservation fee may be refunded or applied to the account if the appointment is kept but is non-refundable if the appointment is cancelled or failed. Patients that fail to adhere to our cancellation and failed policy may be subject to same day scheduling protocol or dismissed from the office.

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/Guardian Signature:_____ Date: _____

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CONSENT FOR FRENECTOMY

DIAGNOSIS:

After a careful oral examination and study of my (or my child's) mouth, I have been advised that the examination demonstrates abnormal tension/shortened bands under the tongue, central upper lip or other areas in the mouth and that these bands may be related to symptoms being experienced.

RECOMMENDED TREATMENT:

In order to treat this condition, the doctor has recommended a procedure to release the tight bands (Frenectomy). I understand that a topical numbing gel will be utilized and an injected local anesthetic may be administered to me as part of the treatment. Vitamin K is a recommended treatment prior to undergoing any infant surgical procedure - the lack of vitamin K is associated with increased rates of neonatal hemorrhage.

PRINCIPAL RISKS AND COMPLICATIONS:

I understand a small number of patients experience problems after the procedure.

Risks include:

- Pain
- Bleeding (especially if vitamin K has not been administered)
- Infection
- Numbness
- Damage to saliva glands (resulting in blockage or ranula) and/or saliva ducts
- Damage to underlying structures (ie: muscle and nerve fibers, blood vessels, etc.)
- Aversion to any feeding
- Reattachment of the bands causing return of symptoms
- Failure to improve
- Need for repeat surgery or other surgeries (to treat complications)

NECESSARY FOLLOW-UP CARE AND SELF-CARE:

I understand that failure to follow recommendations could lead to ill effects, which is my sole responsibility. I know it is important to abide by the specific instructions given by the doctor. Continued involvement with your lactation consultant, speech pathologist, myofunctional therapist or other health care professional is mandatory and critical in improving symptoms.

I have asked all of my questions and have had time to discuss options with my surgeon.

By signing, I elect to proceed with the procedure for myself (or my child).

Parent/Guardian Signature: _____

Date: _____

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PATIENT HISTORY

Today's Date: _____

Patient's Name: _____

Patient's DOB: _____

Pediatrician's/Primary Care Doctor's Name: _____

What are the main concerns that brought you in today? _____

_____

_____

_____

_____

PATIENT'S SYMPTOMS

Is the patient undergoing any type of therapy for the concerns or issues mentioned above? ❍ Yes ❍ No

If yes, please specify which type(s) of therapies and the name(s) of the providers: _____

_____

_____

_____

Has the patient been previously treated for a tongue and/or lip tie? ❍ Yes ❍ No

If yes, please specify: _____

_____

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