



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 N/A STUDENT STATUS: Full-time Part-time N/A

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: _____



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? _____



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



THIS QUESTIONNAIRE IS FOR AGE 18 YEARS AND OVER

PERIODONTAL RISK ASSESSMENT

Patient Name: _____ Today's Date: _____

Do you have a history of any of the following?

		Amount Per Day?	Used for How Many Years?	If You Quit, List What Year
Cigarette Smoking	<input type="radio"/> Yes <input type="radio"/> No	_____	_____	_____
Cigar Smoking	<input type="radio"/> Yes <input type="radio"/> No	_____	_____	_____
Pipe Smoking	<input type="radio"/> Yes <input type="radio"/> No	_____	_____	_____
Chewing Tobacco	<input type="radio"/> Yes <input type="radio"/> 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:**
(Prednisone, Azathioprine, Cyclosporins, Corticosteroids [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.

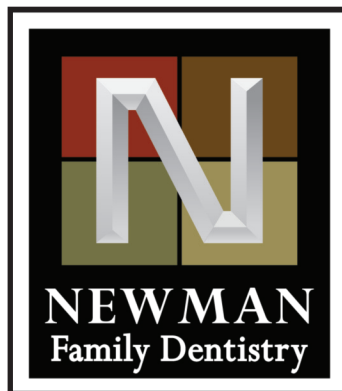
SIGNATURE REQUIRED

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



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: _____