NEWMAN
Family Dentistry

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 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.

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 by check, cash, credit card, debit card or Care Credit.

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

TREATMENT PLANS: All treatment plans given by Newman Family Dentistry are an ESTIMATE only.

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.

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.

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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Revised 3-2023

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: _____

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NEW PATIENT QUESTIONNAIRE

Patient Name:_____ Today's Date:_____

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

What are your main concerns 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? _____

_____