New Patient Registration Form

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Welcome to our Practice

Chart#

FOR OFFICE USE ONLY

Patient's Last Name *

Patient's First Name *

MI

Preferred Name

Title

Mr/Ms/Mrs/etc

Gender

Male Female

Family Status

Married Single Child Other

Birth Date

MM/dd/yyyy

Social Security Number

___-__-____

Prev. Visit

Email Address

Best time to call

Home Phone

(___) ___-____

Mobile Phone

(___) ___-____

Work Phone

(___) ___-____

Extension

Fax Number

(___) ___-____

Other Number

(___) ___-____

Address *

Street Address, City, State, Zip-Code

Whom may we thank for referring you to our practice?

In an emergency who should be notified?

Emergency Contact Name

Phone number

(___) ___-____

Relationship

Employment Information

The following is for:

the patient the person responsible for payment both not applicable

Employer Name

Phone #

(___) ___-____

Employer Address

Street Address, City, State, Zip Code

Responsible Party Information:

This only needs to be completed if the insurance subscriber is someone other than the patient, or your are the parent/guardian of the patient.

The following is for:

- ○ the patient's spouse
- ○ the person responsible for payment
- ○ both
- ○ neither-not applicable

Last Name | First Name | MI | Preferred Name

Title

Mr/Ms/Mrs/etc

Gender

- ○ Male
- ○ Female

Family Status

- ○ Married
- ○ Single
- ○ Child
- ○ Other

Birth Date

MI DI YY

Social Security Number

___-__-____

Drivers License #

Email Address | Best time to call | Home Phone | Mobile Phone

(___) ___-____

Work Phone | Extension | Fax Number | Other Number

(___) ___-____

Address

Street Address, City, State, Zip-Code

Primary Dental Insurance

Insured Last Name

Insured First Name

MI

Insured's Birth Date

MI DI YY

ID #

Group Number

Insured's Address

Street Address, City, State, Zip Code

Insured's Employer Name

Employer Address

Street Address, City, State, Zip Code

Patient's relationship to insured:

- Self
- Spouse
- Child
- Other

Insurance Plan Name

Insurance Company Phone #

(___) ___-____

Insurance Address

Street Address, City, State, Zip Code

Insurance Authorization:

By checking this box,

I authorize my insurance company to pay the dentist all insurance benefits rendered.
I authorize the use of this electronic signature on all insurance submissions.
I authorize the dentist to release all information necessary to secure the payment of benefits.
I understand that I am financially responsible for all charges whether or not paid by insurance.

Dental Information

What is your immediate concern?

Previous Dentist Name

Phone Number (___) ___-____

Date of most recent dental exam MM DD YYYY

Date of most recent dental x-rays MM DD YYYY

Is there anything about the appearance of your smile that you would like to change? *

- Yes
- No

Check all that apply:

- Had complications from past dental treatment
- Had trouble getting numb
- Had any reactions to local anesthetic
- Had/have braces, orthodontic treatment
- You experience dry mouth
- Any teeth sensitive to hot, cold, biting, sweets or avoid brushing any part of your mouth
- Food gets trapped between any teeth
- Have you ever whitened or bleached your teeth
- Have you experienced popping and/or clicking of your jaw joint
- You have difficulty chewing
- You clench or grind your teeth
- You wear or have worn a bite appliance
- Gums bleed when brushing or flossing
- Treated for gum disease or were told you have lost bone around your teeth
- Have you ever had gum surgery
- Noticed an unpleasant taste or odor in your mouth
- Experienced gum recession
- Had any teeth become loose on their own (without injury)
- Experienced a burning sensation in your mouth
- You snore or wake up frequently during the night
- Wear a retainer or Night Guard

If any of the checked boxes need further explanation, please describe

Consent for Services and Financial Policy

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care.
Financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in full at the time services are performed unless other arrangements are made.

Patients with dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A fee of $50 per hour of scheduled appointment will be charged for patients who miss or cancel without a 48 hour notice.

I understand that any fee estimate for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment, or within five (5) days of billing if credit is extended. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me to discuss this statement or my treatment.

☐ **By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the Administration Form.** *

HIPAA Acknowledgement

I understand that I may inspect or copy the protected health information described by this authorization.

I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form.

I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality,

I allow this practice to disclose my Protective Health Information to the following individuals: (This information could include: Name, Diagnosis, Test Results, Images and Account Information.)

Name

Relationship to Patient

☐ **By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the HIPAA Disclosure Form.** *

Response Date

10/08/2025