Date_____

PATIENT REGISTRATION

Phone No._____

PATIENT NAME_____ E-Mail _____
First Middle Last

Birthdate_____ Mr. Mrs. Miss Ms single married divorced widowed

Address_____
Street City State Zip

PATIENT
Employer_____

Bus. Address_____
_____

Bus. Phone or Cell _____
Bus. Address_____
SS#_____

YOUR SPOUSE
Name_____

Birthdate_____SSN#_____

Employer_____
Bus. Address_____
Bus. Phone or Cell_____

PERSON FINANCIALLY RESPONSIBLE

Name_____ Birthdate_____ SSN#_____

Address_____Phone No. _____
Street City State Zip

Employer_____Address_____
Bus. Phone No._____ _____
Relationship to patient_____

DENTAL INSURANCE COVERAGE Yes No

Employee Name_____Birthdate_____SSN#_____

Insurance Company_____Group No._____
Employer_____ Address _____
_____

SECONDARY INSURANCE COVERAGE Yes N

Employee Name_____Birthdate_____SSN#_____

Insurance Company_____Group No._____
Employer_____ Address _____
_____

Nearest Friend or Relative to Contact in case of Emergency? _____
Address_____Phone No._____

REFERRED TO US BY _____

AUTHORIZATION AND RELEASE: *I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and /or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. Sign*_____.

Date _____

Name _____

Best phone number to reach you _____

Birthdate _____

New Patient Medical History

Physician name _____ Physician Phone _____

Are you in in general good health at this time? **Y N** if no, list _____

Do you use tobacco products (smoking, snuff, chew etc…) **Y N**

Are you currently under any medical treatment? **Y N** if yes, list _____

Have you been hospitalized in the past five years? **Y N** if yes, list _____

Do you take blood thinners? **Y N**

Joint Replacement – Have you had an orthopedic total joint (hip, knee, etc… replacement)? **Y N**

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? **Y N**

Were you treated or are you presently scheduled to begin treatment with the intravenous **bisphosphonates** (like Aredia, Zometa Boniva, Actonel, Fosamax) for bone pain? **Y N**

Do you have an artificial (prosthetic) heart valve? **Y N**

Do you have congenital heart disease? **Y N**

Women only

Pregnant **Y N** **Number of weeks:** _____

Nursing **Y N**

Taking birth control **Y N**

Allergies

Are you allergic to or have you had a reaction to:

Local anesthetics	**Y N**	Codeine or narcotics	**Y N**
Aspirin	**Y N**	Latex	**Y N**
Penicillin	**Y N**		

*If you have a list of medications we would like to make a copy for our records.

Dr. would also like you to bring an updated list of medications with you when you come to your appointments.

Date _____

Name _____

Best phone number to reach you _____

Birthdate _____

Have you ever had or do you have:

High Blood Pressure		Respiratory Disease		Sinus	
Stroke		Asthma		Recurrent Infections	
Arthritis		Organ Transplant		Autoimmune disease	
Rheumatoid Arthritis		Fibromyalgia		Gastrointestinal Disorder	
GERD/Acid Reflux		Diabetes		Liver Disease	
Neurological Disorders		Alzheimer's/ Dementia		Depression/ Anxiety	
Heart Disease		Pacemaker/ Defibrillator		Valve Replacement	
COPD		Tuberculosis		Allergies	
Chemotherapy		Radiation Therapy		Artificial Joints	
Sleep Apnea		Cpap		Multiple Sclerosis	
Crohn's Disease		Ulcers		Thyroid Disease	
Kidney Disease		Hepatitis		Cholesterol	
Bronchitis		Osteoporosis		Persistent Swollen Glands	
Severe Headaches/ Migraines		Sexually Transmitted Disease		Blood Transfusion	
Glaucoma		Rheumatic Fever			

Please list medications you are currently taking _____

_____

*Other medical conditions not listed on this form

_____

Name_____ Date_____

DENTAL HISTORY

Welcome to our office. Please answer the following questions so that we may best serve your individual needs.

What is the purpose of your visit today? _____

How often do you feel you need a dental exam and cleaning? _____

How often do you brush? _____ floss? _____

When was your last dental visit? _____ for what? _____

When were your last x-rays taken? _____

Do you:

Clench/grind your teeth?	yes	no
Bite your cheeks/lips?	yes	no
Mouth breathe?	yes	no
Smoke/chew tobacco?	yes	no
Bite fingernails?	yes	no

Have you ever had:

Orthodontic treatment?	yes	no
Periodontal treatment?	yes	no
Root canal treatment?	yes	no
Oral surgery?	yes	no
Serious mouth/head injury?	yes	no

Are any teeth sensitive to:

Hot or cold?	yes	no
Sweets?	yes	no
Biting/chewing pressure	yes	no

Do your gums bleed or hurt?	yes	no
Do you have areas where food impacts?	yes	no
Do you have any loose teeth?	yes	no

Have you experienced:

Clicking/popping of the jaw?	yes	no
Headaches/neck aches?	yes	no
Extraction complications?	yes	no
Frequent bad breath?	yes	no
Unpleasant taste in mouth?	yes	no

Are you satisfied with the appearance of your teeth? yes no

Do you feel nervous about dental treatment? yes no
If so please explain_____

Have you ever had a bad dental experience? yes no
If so please explain _____

What is important to you and how can we help you with your dental treatment?

Thank you!

Patient Signature _____

Thomas E. Newman DDS Ltd

Acknowledgement of Receipt Of Notice of Privacy Practices

(You may refuse to Sign this acknowledgement)

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
(Please Print Name)

_____
(Signature)

_____
(Date)

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices; but acknowledgement could not be obtained because:

___ Individual refused to sign

___ Communications barriers prohibited obtaining the acknowledgement

___ An emergency situation prevented us from obtaining acknowledgement

___ Other (Please specify)

_____

Thomas E. Newman, Jr., D.D.S.
468 Spring Road
Elmhurst, IL 60126
www.newmandds.com
630.532.5310

Consent For Services

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 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.

I understand that any fee estimate for this dental care can only be extended for a period of **three 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 10 days of billing if credit is extended.**

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

___ I have read the above conditions of treatment and payment and agree to their content.

Signature of patient, parent, or guardian (responsible party):

Signature: _____ Date: _____

Relationship to Patient: _____

Date_____

Pediatric Name_____

Medical/Dental Birthdate_____ Age____

Dental History

Has your child had dental treatment prior to this appointment? Yes No

If yes explain_____

Are you aware of any problems at this time? Yes No

If yes explain _____

Does your child have a positive attitude about this dental visit? Yes No

Have there been any unpleasant dental experiences? Yes No

Does your child:

Brush daily	Y	N	Bite fingernails	Y	N
Floss	Y	N	Suck thumb	Y	N
Receive fluoride	Y	N	Mouth breathe	Y	N

Please explain any concerns you may have about your child's dental health_____

Medical

Child's Physician_____ Phone_____

Is your child under the care of a physician at this time?

Please list medications _____

Is your child in general good health? Yes No

Has your child had?

Rheumatic Fever	Yes	No	Food Allergies	Yes No
Heart disease	Yes	No	Drug Allergies	Yes No
High/low blood pressure	Yes	No	Asthma/Hay Fever	Yes No
Blood disorders	Yes	No	Arthritis	Yes No
Bleeding/ bruising	Yes	No	Diabetes	Yes No
Hepatitis	Yes	No	Kidney/ Bladder Problems	
HIV+/AIDS	Yes	No		