New Patient Registration Form

PATIENT INFORMATION			
Last name:	**First Name:**		**Middle Initial**:
Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Other _____	**Social Security #:**	**Birth Date**:	**Sex**: ❑ M ❑ F
Street Address:	**City**:	**State/Zip Code**:	
Email address:			
Cell Phone:	**Home Phone**:	**Work Phone**: **Ext**:	
Primary Care Physician Name:	**Physician Address**:	**Physician Phone**:	
Employer Name:	**Employer Address**:	**Occupation**:	

Have you ever had any of the following? Please check those that apply:

❒ ADHD
❒ AIDS/HIV
❒ Allergies: _____
❒ Anemia
❒ Anxiety Disorder
❒ Arthritis
❒ Artificial Joints
❒ Asthma
❒ Autism
❒ Blood Disease
❒ Cancer
❒ Codeine Allergy
❒ Diabetes
❒ Developmental Disorder
❒ Dizziness
❒ Epilepsy
❒ Excessive Bleeding
❒ Fainting
❒ Facial Pain
❒ Glaucoma
❒ Growths
❒ Hay Fever
❒ Head Injuries
❒ Headaches
❒ Heart Disease
❒ Heart Murmur
❒ Hepatitis
❒ High Blood Pressure
❒ Jaundice
❒ Jaw Locking
❒ Jaw Pain
❒ Kidney Disease
❒ Liver Disease
❒ Mental Disorders
❒ Nervous Disorders
❒ Pacemaker
❒ Penicillin Allergy
❒ Pregnancy
Due Date: _____
❒ Radiation Treatment
❒ Respiratory Problems
❒ Rheumatism
❒ Sinus Problems
❒ Sleep Apnea
❒ Special Education
❒ Stomach Problems
❒ Stroke
❒ Snoring
❒ Tuberculosis
❒ Tumors
❒ Ulcers
❒ Venereal Disease
❒ Other:
_____
_____
_____

Do you smoke?	❑ Yes ❑ No	If yes, how many per day:
Have you ever had any complications following dental treatment?	❑ Yes ❑ No	If yes, please explain:
Have you been admitted to a hospital or needed emergency care during the past two years?	❑ Yes ❑ No	If yes, please explain:
Are you now under the care of a physician?	❑ Yes ❑ No	If yes, please explain:
Do you have any health problems that need further clarification?	❑ Yes ❑ No	If yes, please explain:
Please list all medications and dosages you are currently taking:		

To the best of my knowledge, all the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ _____
Patient/Guardian Name (Print): Date:

_____ _____
Patient/Guardian Name (Signature): Date:

RESPONSIBLE PARTY INFORMATION

The following is for: ❑ Patient ❑ Person Responsible for Payment ❑ Relationship to Patient _____

Name:	**Sex**: ❑ M ❑ F	**Marital Status**: ❑ Single ❑ Married ❑ Divorced ❑ Other _____

SS#:	**Birth Date**:	**Home Phone:**	**Work Phone:**	**Cell Phone:**

Street Address:	**City/State/Zip:**

INSURANCE INFORMATION

PRIMARY INSURANCE:

Occupation:	**Employer**:	**Employer Address**:	**Employer Phone**:

Name of Primary Insurance:

Subscriber's Name:	**Birth Date**:	**Group #**:	**ID #**:

Patient's Relationship to Subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other: _____

SECONDARY INSURANCE:

Occupation:	**Employer**:	**Employer Address**:	**Employer Phone**:

Name of Secondary Insurance:

Subscriber's Name:	**Birth Date**:	**Group #**:	**ID #**:

Patient's Relationship to Subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other: _____

Assignment and Release

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign all insurance benefits directly to **ProHEALTH Dental** that are otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payments of benefits and authorize the use of this signature on all insurance submissions.

_____ _____

Patient/Guardian Name (Print): Date:

_____ _____

Patient/Guardian Name (Signature): Date:

Consent for Dental Treatment and Acknowledgement of Receipt of Information

State law requires our office to obtain your consent for your contemplated oral care and dental treatment. Please read this form carefully and ask about anything you do not understand. We will be pleased to further explain and discuss your concerns and questions.

I hereby authorize consent for oral and dental treatment that may include, but not limited to, the following: examination, radiographs (x-rays), diagnosis, dental prophylaxis (cleaning), fluoride treatment, restorations (i.e. fillings, pulpotomy, stainless steel crowns), anesthesia, oral surgery (extractions), interceptive orthodontic treatment and emergency treatment.

I understand that during any planned procedure, unforeseen conditions may arise that may necessitate treatment or procedures in addition to, or different from those originally discussed. In addition, although I am not advised that positive results are expected, the possibility and nature of complications cannot be accurately anticipated and, therefore, there can be no guarantee expressed or implied either as to the result of treatment.

Although their occurrence is not frequent, some risks and complications are known to be associated with dental or oral surgery procedures. These risks include, but are not limited to the following: nausea following anesthesia, numbness, infection, swelling, prolonged bleeding, discoloration, vomiting, allergic reactions, swallowing or aspiration of various materials (i.e. stainless-steel crowns), injury to the tongue, lips, cheeks, damage to possible loss of existing teeth and/or restorations (fillings), injury to nerves near the treatment site and fracture of a tooth root which may require additional surgery for its removal. I further understand and accept that complication may require additional medical, dental or surgical treatment and may require hospitalization.

Understanding this Form

I hereby state that I have read and understand this consent form, that I have been given the opportunity to ask questions that I might have and that all questions have been answered in a satisfactory manner. I understand that I have the right to be provided with answers to questions that may arise during the course of my treatment.

I further understand that I am free to withdraw my consent to treatment at any time, and that my consent will remain in effect until such time that I choose to withdraw it.

_____ _____

Patient/Guardian Name (Print): Date:

_____ _____

Patient/Guardian Name (Signature): Date:

Referral Information

Please tell us how you learned about our practice. (Select ALL that apply.)

❑ ProHEALTH Doctor:

Name: _____

❑ Mount Sinai Doctor:

Name: _____

❑ Another Dentist/Doctor:

Name: _____

❑ Friend/Family

❑ Website

❑ Internet Search (Basic Search)

❑ Insurance Company

❑ Walk in / Saw Sign

❑ Ad in Local Publication

❑ ProHEALTH E-Mail

❑ ProHEALTH Mailing

❑ ProHEALTH Dental Staff

❑ ProHEALTH Employee

❑ ProHEALTH Patient

❑ Other: _____

Financial Agreement

Our goal is to provide the highest quality of dental care possible as well as a positive patient experience. Please see our financial policy.

All accounts are due and payable at time of service.
If a procedure requires multiple appointments, payment may be paid with a minimum of two payments or based on the number of appointments to complete treatment.

Payment Options:

- Cash
- Check
- Visa / MasterCard / Discover / AMEX
- The Lending Club

Patients with Insurance: The patient/guarantor is responsible for the **estimated** non-covered portion, procedures and/or deductibles at the time of the service. Due to insurance policy changes and/or necessary changes in treatment plans, the insurance coverage may vary from the estimated treatment calculation. I acknowledge this is an estimate only and that I, not the insurance company, am ultimately responsible for payment in full for all services not covered for any reason by my insurance.

Parents not accompanying their child to an appointment must make **prior** arrangements for payment (cash, check or credit card authorization). **Parents accompanying their children** are financially responsible for payment.

There is a processing charge for **non-sufficient funds** or returned checks.

As instruments, chairs and personnel are reserved exclusively for your appointment, there may be a fee charged for changed or broken appointment with less than 24 hours in advance.

_____ _____
Patient/Guardian Name (Print): Date:

_____ _____
Patient/Guardian Name (Signature): Date:

Acknowledgement of Privacy Practices

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the *Health Insurance Portability & Accountability Act of 1996* ***(HIPAA)***. I understand that this information can and *will* be used to:

- Provide and coordinate my treatment among many health care providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers for my health care services.
- Conduct normal health care operations such as quality assessment and improvement activities.

I have been informed of my dental provider's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices*. I understand that my dental provider has the right to change the *Notice of Privacy Practices* and that I may contact this office to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

_____ _____

Patient/Guardian Name (Print): Date:

_____ _____

Patient/Guardian Name (Signature): Date: