

## **New Patient Registration**

First Name:	Last Name		Phone	e:		
Date of Birth:	Social	Email Address				
Address		CIty	State_	Zip_		
Employer		Occupation		Work Phone		
Employer Address						
Employer Address			<i></i>	5tate	_ 210	
Responsible Party if Otl	her than Patient;					
First Name:	Last Name		Phone	e:		
Date of Birth:	Social	E	mail Address			
Address						
Employer		Occupation		_Work Phone		
Employer Address						
_						
Emergency Contact						
First Name:						
Address		CIty	State_	Zip_		
Insurance Information						
Insurance Name		_ Policy Number	er	G	roup #	
Policyholder Name		D.C	).B	Social #		
Insurance Phone Number						
How did you Hear abou	ıt IIS?					
		octor	In	suranco		
			Insurance Website Google			
A Iviai ketei	Drove b	·y	website	doogle	racebook	
Primary Physician						
Name	Address		City	Sta	te Zip	
Phone			-			
Health History						
Primary Concerns:	When พ	vas the last time	you visited the	dentist:	_	
Are you sensitive to HOT fo	oods or liquids?:	_				
Are you sensitive to COLD	foods or liquids?:					
How often are you brushir	ng your teeth?	_ Do your gums	bleed?:	_		
Do you grind your teeth?:_						
Do you want to change the			-			
<b>J</b>	3		_			
For Women:						
Are you taking hirth contro	al nills? Are vo	u nreanant?	\//ook #·	Are you nur	sing?	

Y N Abnormal Bleeding Y N Colitis Y N Liver Disease Y N Alcohol Use Y N Congenital Heart Defect Y N Heart Surgery Y N Lupus Y N Anemia Y N Hemophilia Y N Pacemaker Y N Artificial Bones/Joints Y N Emphysema Y N Hepatitis Y N Radiation Treatment Y N Artificial Valves Y N Fever Blisters Y N Herpes Y N Seizures Y N Asthma Y N Glaucoma Y N High Blood Pressure Y N Tobacco Use Y N Cancer Y N Headaches Y N HIV+/AIDS Y N Tuberculosis (TB) Y N Chemotherapy Y N Heart Attack Y N Kidney Problems Y N Venereal Disease Y N Diabetes Y N Heart Murmur  Are you allergic to any of the following? (Please circle Y/N)	Do you or have you experie	enced any o	f the following? (P	lease circ	le Y/N)			
Y N Congenital Heart Defect		-	•			Y N Alc	ohol Use	
Y N Hemophilia Y N Hagadiation Treatment Y N Artificial Bones/Joints Y N Freyer Bisters Y N Herpes Y N Sciures Y N Harpes Y N Sciures Y N Hilly Blood Pressure Y N Tobacco Use Y N Cancer Y N Headaches Y N Hilly Hold Blood Pressure Y N Tobacco Use Y N Cancer Y N Headaches Y N Hilly Hold Y N Herpes Y N Sciures Y N Hore W Y N Headaches Y N Hilly Hold Y N Headaches Y N Hilly Hold Y N Headaches Y N Heart Attack Y N Heart Attack Y N Heart Murmur  Are you allergic to any of the following? (Please circle Y/N) Y N Aspirin Y N Erythromycin Y N Sedatives Y N Beabiturates Y N Heart Murmur  Are you allergic to any of the following? (Please circle Y/N) Y N Aspirin Y N Erythromycin Y N Sedatives Y N Beabiturates Y N Heart Murmur  Are you currently taking any medications? Please list any medications you may be taking below: 1 1 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 2 1 1 2 1 1 2 1 3 1 1 1 1 2 3 1 1 1 2 3 1 2 3 1 3 4 1 3 4 1 1 3 4 1 1 1 2 3 4 1 2 3 4 1 3 4 1 4 1 1 3 4 1 4 1 4 1 4 1 4 1 4 1 4 1 4 1 5 5 1 5 1 1	•			/	Y N Lupus			
Y N Hepatitis Y N Radiation Treatment Y N Artificial Valves Y N Fever Bilsters Y N Helph Blood Pressure Y N Tobacco Use Y N Ashma Y N Glaucoma Y N High Blood Pressure Y N Tobacco Use Y N Chemotherapy Y N Heart Attack Y N Kidney Problems Y N Venereal Disease Y N Diabetes Y N Chemotherapy Y N Heart Attack Y N Kidney Problems Y N Venereal Disease Y N Diabetes Y N Diabetes Y N Heart Murmur  Are you allergic to any of the following? (Please circle Y/N) Y N Aspirin Y N Erythromycin Y N Sedatives Y N Barbiturates Y N Berpitrurates Y N Jewelry/Metals Y N Suffa Drugs Y N Codeine Y N Latex Y N Tetracycline Y N Dental Anesthetics Y N Penicillin Y N Other  Are you currently taking any medications? Please list any medications you may be taking below:  1	•				·	nes/Joints	Y N Emphysema	
Y N Herpes Y N Educoma Y N High Blood Pressure Y N Heberculosis (TB) Y N Cancer Y N Headaches Y N Heart Attack Y N Kidney Problems Y N Venereal Disease Y N Denbetes Y N Denteral Attack Y N Kidney Problems Y N Heart Attack Y N Heart Murmur  Are you allergic to any of the following? (Please circle Y/N) Y N Aspirin Y N Erythromycin Y N Suffa Drugs Y N Sodative Y N Jewelry/Metals Y N Jewelry/Metals Y N Jewelry/Metals Y N Dental Anesthetics Y N Penicillin Y N Other  Are you currently taking any medications? Please list any medications you may be taking below: 12	·	Y N Radia		Y N Art				
Y N High Blood Pressure Y N Tobacco Use Y N Cancer Y N Headaches Y N HIV-r/NDS Y N Undervolvesis (TB) Y N Chemotherapy Y N Heart Attack Y N Hidney Problems Y N Venereal Disease Y N Diabetes Y N Diabetes Y N Heart Murmur  Are you allergic to any of the following? (Please circle Y/N) Y N Aspirin Y N Erythromycin Y N Sedatives Y N Barbiturates Y N Jewelry/Metals Y N Sulfa Drugs Y N Codeine Y N Latex Y N Tetracycline Y N Dental Anesthetics Y N Penicillin Y N Other  Are you currently taking any medications? Please list any medications you may be taking below:  1	•						Y N Glaucoma	
Y N Hilv-/AIDS Y N Venereal Disease Y N Diabetes Y N Chemotherapy Y N Heart Murmur  Are you allergic to any of the following? (Please circle Y/N) Y N Aspirin Y N Erythromycin Y N Sedatives Y N Godeine Y N Dental Anesthetics Y N Dental Anesthetics Y N Dental Hances Y N Dental Anesthetics Y N Penicillin Y N Other  Are you currently taking any medications? Please list any medications you may be taking below: 1	•	ressure						
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Y N Jewelry/Metals Y N Sulfa Drugs Y N Codeine Y N Latex Y N Tetracycline Y N Dental Anesthetics Y N Penicillin Y N Other  Are you currently taking any medications? Please list any medications you may be taking below:  1	•							
Y N Jewelry/Metals Y N Dental Anesthetics Y N Penicillin Y N Other  Are you currently taking any medications? Please list any medications you may be taking below:  1		-		N)				
Are you currently taking any medications? Please list any medications you may be taking below:  1	Y N Aspirin	Y N Eryth	•	Y N Sec	datives	Y N Bar	biturates	
Are you currently taking any medications? Please list any medications you may be taking below;  1	Y N Jewelry/Meta	als	Y N Sulfa Drugs		Y N Codeine		Y N Latex	
I understand that I am responsible for payment of services rendered by Midtown Family Dentistry, and also responsible for paying any copayment and deductible that my insurance does not cover. I hereby authorize the Midtown Family Dentistry to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.  I affirm that the information I have given is correct to the best of my knowledge. All information herein will be held in the strictest confidence and it is my responsibility to inform Midtown Family Dentistry of any changes in my medical status. I truthfully revealed all aspects of my/my child's health history and I realize that failure to have done so may have negative consequences for my/my child's health and the success of my/my child's treatment. I also agree to cooperate fully with the recommendations of the Dentist and Dental Hygienist and I realize that failure to do so may result in less than optimum results and compromise the life span of my/my child's treatment. I also agree to follow the recommendations for home care and the schedule for future tooth cleaning and check-ups. I realize that failure to do my part in the maintenance of my/my child's oral health will compromise the success of any dental treatment received.  I hereby authorize Midtown Family Dentistry and staff to take radiographs, study models, intraoral photographs, or any other diagnostic tools, all deemed appropriate by dentist to make a thorough diagnosis of the patient's dental needs. I also authorize the dentist to perform any and all forms of treatment including cleaning, fluoride and sealants (back teeth have grooves and pits in which decay usually start. An assistant will "seal" the grooves with a plastic coating to help prevent the decay from starting. No anesthetic is needed. Good oral hygiene and avoidance of sticky and hard food/candles are important to maintain sealants). And further authorize and consent that the den	Y N Tetracycline		Y N Dental Anesth	netics	Y N Penicillin		Y N Other	
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	strictest confidence and it truthfully revealed all aspeconsequences for my/my or lagree to cooperate fully result in less than optimum recommendations for home the maintenance of my/my lhereby authorize Midtow diagnostic tools, all deemethe dentist to perform any in which decay usually star No anesthetic is needed. Gand further authorize and antibiotics, local anesthesis cause allergic reactions caureaction). Administration of indefinitely. Women of chill rely on other methods of bunderstand and acknowle reasonably foreseeable risk	is my respoi cts of my/m hild's health with the rec n results and e care and to child's oral m Family De d appropria and all form t. An assista ood oral hyo consent that n ("shots") a sing rednes f local anest dbearing ag irth control edge that I is ss associate	nsibility to inform I by child's health his and the success of commendations of decompromise the lathe schedule for full the schedule for full I health will compresentistry and staff to the by dentist to man ans of treatment incomorated will "seal" the graph and avoidance at the dentist choosed at	Midtown story and if my/my the Dent life span iture toot omise the to take race ake a thor cluding cle rooves wi ce of stick ose and el ations giv issue, pair ny cause n atibiotics r ncy. o be treat g my cond	Family Dentistry of I realize that failure child's treatment. tist and Dental Hygo of my/my child's treatment he cleaning and chees success of any derediographs, study mough diagnosis of the earling, fluoride and eith a plastic coating by and hard food/camploy such assistaten to the patient ben, itching, vomiting herve damage (paremay make birth correct by the dentist. Itition. Alternative to	e to have de to help prendes are innee as she de fore, durin and/or and sthesia) that trol medica	es in my medical status. One so may have negative realize that failure to do also agree to follow the alize that failure to do my ent received. Oral photographs, or any adental needs. I also authorate the decay from star apportant to maintain seadeemed fit. I understanding and after treatment, caphylactic shock (severent can last for days, montations ineffective and needs and after the decays montations ineffective and needs after the decays and the decay for the decay fit and the decay for the de	I so may y part in other horize and pits rting. I that an allergic hs or ed to
Signature: Date:	associated risks and benefi	is nave bee	n adequately prese	ented to r	ne.			
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the CDC, and the ADA.



## **HIPAA Privacy Policy**

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment
- a means of communication among the many health professionals who contribute to my care
- a source of information for applying my diagnosis and surgical information to my bill
- a means by which a third- party payer can verify that services billed were actually provided and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon.

Patient Name:				
Signature:			Date	e
Relationship to Patient:	Self	or	Guardian	(please circle one)