Midtown
FAMILY DENTISTRY

New Patient Registration

First Name:_____ Last Name_____ Phone:_____
Date of Birth:_____ Social_____ Email Address _____
Address_____ CIty_____ State_____ Zip_____

Employer _____ Occupation _____Work Phone _____
Employer Address _____ City _____ State _____ Zip _____

Responsible Party if Other than Patient;

First Name:_____ Last Name_____ Phone:_____
Date of Birth:_____ Social_____ Email Address _____
Address_____ CIty_____ State_____ Zip_____

Employer _____ Occupation _____Work Phone _____
Employer Address _____ City _____ State _____ Zip _____

Emergency Contact

First Name:_____ Last Name_____ Phone:_____
Address_____ CIty_____ State_____ Zip_____

Insurance Information

Insurance Name _____ Policy Number _____ Group #_____
Policyholder Name _____ D.O.B _____ Social #_____
Insurance Phone Number _____

How did you Hear about US?

A friend/patient _____ A Doctor _____ Insurance _____
A Marketer _____ Drove By _____ Website _____ Google _____ Facebook _____

Primary Physician

Name _____ Address _____ City_____ State _____ Zip _____
Phone _____ Fax _____ Email _____

Health History

Primary Concerns:_____When was the last time you visited the dentist:_____
Are you sensitive to HOT foods or liquids?:_____
Are you sensitive to COLD foods or liquids?:_____
How often are you brushing your teeth?_____ Do your gums bleed?:_____
Do you grind your teeth?:_____ Do you have any pain in your jaw?:_____
Do you want to change the arrangement of your teeth?:_____

For Women:

Are you taking birth control pills? _____ Are you pregnant? _____Week #: _____ Are you nursing? _____

Do you or have you experienced any of the following? (Please circle Y/N)

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)

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._____ 2._____

3._____ 4._____

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 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 dentist choose and employ such assistance as she deemed fit. I understand that antibiotics, local anesthesia ("shots") and all other medications given to the patient before, during and after treatment, can cause allergic reactions causing redness and swelling of tissue, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). Administration of local anesthesia ("shots") may cause nerve damage (paresthesia) that can last for days, months or indefinitely. Women of childbearing age need to know antibiotics may make birth control medications ineffective and need to rely on other methods of birth control to prevent pregnancy.

I understand and acknowledge that I may choose not to be treated by the dentist. The dentist has explained to me the reasonably foreseeable risks associated with not treating my condition. Alternative treatment plans with their foreseeable associated risks and benefits have been adequately presented to me.

Signature:_____ Date: _____

Our office is HIPAA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, 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**_____

Relationship to Patient: Self or Guardian (please circle one)