New Patient Registration Form

PATIENT INFORMATION: Please fill out ALL information clearly and accurately.

Date: _____ Email _____ Best Contact #: ( ) _____

Name: _____ Age _____ Sex _____ Mobile Phone ( ) _____
Last First MI

Address: _____ Apt _____ Home Phone ( ) _____

City: _____ State: _____ Zip _____ Work Phone ( ) _____

Birthdate: _____/_____/_____ SSN: _____-_____-_____ Marital Status: □ Single □Married □Divorced □Separated □Child

Driver's License Number_____ State _____ Employer: _____

In case of emergency, contact: _____ Relation: _____ Phone ( ) _____

Are any of your family members patients of this practice? □YES □NO Name(s) and relation: _____

REFERRAL INFORMATION: Who may we thank for referring you? _____

RESPONSIBLE PARTY INFORMATION: (who is responsible for paying any balance?)

Name: _____ Age _____ Home Phone ( ) _____
Last First MI

Address: _____ Apt _____ Work Phone ( ) _____

City: _____ State: _____ Zip _____ Mobile Phone ( ) _____

Birth date: _____SSN ____-____-____ Email _____ Driver's License Number _____State ____

Employer: _____ Employer's Address _____

INSURANCE INFORMATION:

Primary Insurance Plan Name & Address: _____ Phone Number: _____

Name of Insured: _____ Birthdate: _____ SSN: _____-_____-_____
Last First

Policy #: _____ Group #: _____ Patient Relationship to Insured: □Self □Spouse □Child □Other

Insured's Address: _____ Phone Number: _____
Street City State Zip Code

Insured's Employer: _____ Address: _____

Dental History:

What is the reason for this appointment? _____

How often do you brush? _____

How often do you floss? _____

When was your last dental appointment? _____

What was your last dental appointment for? _____

When was your last dental cleaning? _____

How would you like to improve your smile? _____

	Yes	No
Are you apprehensive about dental treatment?_____	☐	☐
Have you had problems with previous dental treatment?_____	☐	☐
Do your gums bleed when brushing or flossing?_____	☐	☐
Have you been told that you have gum disease?_____	☐	☐
Do you gag easily?_____	☐	☐
Do you have difficulty chewing your food?_____	☐	☐
Are your teeth sensitive to hot foods/liquids?_____	☐	☐
Are your teeth sensitive to cold foods/liquids?_____	☐	☐
Do you clench or grind your teeth?_____	☐	☐
Do you suffer from pain in your jaw?_____	☐	☐
Do you take fluoride supplements?_____	☐	☐

Medical History:

Yes No

Date of last physical exam: _____

□ □ Currently under the care of a physician?
-If yes, Physician's name: _____

□ □ Have you been hospitalized in the past 5 years?
-If yes, for what reason? _____

Current medications: _____

Over the counter supplements: _____

Yes No

□ □ Cardiovascular disease
□ □ Angina
□ □ Arteriosclerosis
□ □ Artificial heart valve
□ □ Congenital heart disease
□ □ Congestive Heart Failure
□ □ Heart attack
□ □ Heart murmur
□ □ Low blood pressure
□ □ High blood pressure
□ □ High Cholesterol
□ □ Mitral Valve Prolapse
□ □ Pacemaker
□ □ Rheumatic Fever
□ □ Anemia
□ □ Blood transfusion
□ □ Hemophilia
□ □ AIDS
□ □ HIV infection
□ □ Autoimmune Disease
□ □ Arthritis
□ □ Rheumatoid Arthritis

□ □ Asthma
□ □ Bronchitis
□ □ Emphysema
□ □ Sinus trouble
□ □ Tuberculosis
□ □ Cancer
□ □ Radiation Therapy
□ □ Chemotherapy
□ □ Diabetes type I
□ □ Diabetes type II
□ □ Claustrophobia
□ □ Acid reflux (GERD)
□ □ Hypothyroidism
□ □ Hyperthyroidism
□ □ Stroke
□ □ Glaucoma
□ □ Hepatitis A/B
□ □ Hepatitis C/D/E
□ □ Epilepsy
□ □ Seizures
□ □ Alzheimer's
□ □ Dementia

□ □ Osteoporosis
□ □ Joint replacement
□ □ Depression
□ □ Anxiety
□ □ Alcohollism
□ □ Drug abuse/addiction

Allergies:

□ □ Aspirin
□ □ Penicillin
□ □ Amoxicillin
□ □ Clindamycin
□ □ Erythromycin
□ □ Sulfa drugs
□ □ Latex
□ □ Other: _____

Women:

□ □ Pregnant
If yes, Due date _____
□ □ Nursing
□ □ Taking contraceptives (birth control)

Patient Treatment Consent:

- I authorize the Dentist(s) or designated staff treating me to perform such diagnostic aids deemed appropriate to make a thorough diagnosis of my dental needs. Upon such diagnosis, I authorize the Dentist(s) to perform all recommended treatment and therapeutic procedures to include administering medications as prescribed by the Dentist(s) and mutually agreed upon by me.
- I assign all dental insurance benefits to which I am entitled to the extent permitted under my dental insurance policy(s) to the Dentist. This form also authorizes Paragon Dental to submit insurance claim forms and receive payment directly from my insurance carrier with the notation "Signature on File". I authorize my Dentist(s) to release treatment records, x-rays and any other information deemed pertinent to my insurance carrier as necessary or requested.
- I agree to be responsible for payment of all services rendered on my behalf or my dependents. I agree that any claims the carrier does not pay or any balance that extends beyond 60 days from the date of treatment may be assessed a service charge of 5% per month.

We strive to give each patient a courtesy call one to two days in advance of your scheduled dental visit. However, <u>you are expected to keep your appointment time with or without the courtesy call</u>. Therefore we ask your consideration and that you kindly give 48-hour notice if you are unable to keep your appointment. Please note that if 48-hour notice is not given, there may be a $60 per hour for a broken appointment fee. A broken appointment is a loss to yourself, your dentist and his team members, and to another patient who could have had that appointment time. <u>We reserve the right to terminate your relationship with our office after repeated broken appointments without 48-hour notice.</u>

_____ _____

Patient Name ***Patient or Responsible Party Signature*** ***Date***

****

I have filled out my New Patient Registration Form to the best of my knowledge.

_____ _____

Patient Name ***Patient or Responsible Party Signature*** ***Date***

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I have received Paragon Patient Business Policy and Notice of Privacy Practices. I have read, understand and agree to the provisions of the said policies. I understand that by declining to sign, I will not be treated at Paragon Dental.

_____ _____

Patient Name ***Patient or Responsible Party Signature*** ***Date***

<u>PLEASE LIST ADDITIONAL PARTIES TO WHOM WE MAY DISCUSS YOUR INFORMATION:</u>

_____ _____

Please Print Name Date Please Print Name Date