Welcome! Please tell us about yourself…..

Patient First Name: _____ Last Name: _____ Middle Initial: _____

Preferred Name: _____ Birthdate: _____ Sex: ☐ Male ☐ Female

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed Student Status: ☐ Full time ☐ Part time

Cell phone # : _____ I would like to receive correspondence via text: ☐ yes ☐ no

Email address: _____ I would like to receive correspondence via email: ☐ yes ☐ no

Home Phone # : _____ Soc. Sec # : _____ Drivers Lic. # _____

Home Address: _____

City, State, Zip: _____

Employer: _____ Work Phone # : _____ ☐ Full time ☐ Part time ☐ Retired

How did you hear about New Image Dentistry? ☐ Facebook, ☐ Internet Search, ☐ Advertisement (please specify type) _____

☐ Friend / Family (name)_____ ☐ Referred by another doctor (name) _____

Do you have a preferred Dentist? _____ Hygienist? _____

Do you have a preferred Pharmacy? _____ Tel # : _____

Parent or Guardian of Patient listed above (if minor):_____

Address if different: _____

Cell phone # :_____ I would like to receive correspondence via text: ☐ yes ☐ no

Email address: _____ I would like to receive correspondence via email: ☐ yes ☐ no

Home Phone # : _____ Soc. Sec # : _____ Drivers Lic. # _____

Employer: _____ Work Phone # : _____

Primary Insurance Information:

Name of Insured: _____ Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured ID or Soc. Sec. # _____ Medicaid ID: _____ Insured Birthdate: _____

Employer Name: _____ Insurance Company: _____

Please provide a copy of Insurance card to the front desk staff.

Secondary Insurance Information:

Name of Insured: _____ Relationship to Insured: __ Self __ Spouse __ Child __ Other

Insured ID or Soc. Sec. # _____ Medicaid ID: _____ Insured Birthdate: _____

Employer Name: _____ Insurance Company: _____

Please provide a copy of Insurance card to the front desk staff.

I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I authorize the doctor to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of this signature on all insurance submissions.

Signature of Patient (Parent or Guardian if minor):

_____ Date : _____

Medical History 2020

Patient Name: Birth Date: Date Created:

Welcome to New Image Dentistry!

Is this your first visit to any of our locations? ☐ Yes ☐ No If yes

Do you have a Primary Care Physician? ☐ Yes ☐ No If yes

Are you currently taking any medications? ☐ Yes ☐ No If yes

Have you ever taken any medication for Osteoporosis? ☐ Yes ☐ No If yes

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Sulfa Drugs
☐ Latex ☐ Metal ☐ Local Anesthetics

What are your symptoms to the above allergy?

☐ Breathing Problems ☐ Hives/Rash ☐ Upset Stomach

Women, are you....

☐ Pregnant? ☐ Trying to get pregnant? ☐ Nursing? ☐ Taking oral or medical contraceptives?

Current Health

Do you have, or have you had, any of the following?

AIDS / HIV Positive	☐ Yes ☐ No	Anemia	☐ Yes ☐ No	Artificial Joint	☐ Yes ☐ No	Bells Palsy	☐ Yes ☐ No
Cold Sores / Fever Blisters	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	Drug Addiction / Alcoholism	☐ Yes ☐ No	Epilepsy / Seizures	☐ Yes ☐ No
Fainting Spells / Dizziness	☐ Yes ☐ No	Frequent Headaches	☐ Yes ☐ No	Hepatitis A	☐ Yes ☐ No	Hepatitis B	☐ Yes ☐ No
Hepatitis C	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Low Blood Pressure	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Thyroid Disorder	☐ Yes ☐ No	Trigeminal Neuralgia	☐ Yes ☐ No	Kidney Disorder	☐ Yes ☐ No	Liver Disorder	☐ Yes ☐ No
Cancer	☐ Yes ☐ No						

Heart Problems

Pacemaker	☐ Yes ☐ No	Mitral valve prolapse	☐ Yes ☐ No	Irregular Heartbeat	☐ Yes ☐ No	Heart Attack / Failure	☐ Yes ☐ No
Cardiac Bypass / Stents	☐ Yes ☐ No	Valve Replacement	☐ Yes ☐ No				

Have you ever had a major heart surgery? ☐ Yes ☐ No If yes

Lung Conditions / Breathing Problems

Asthma	☐ Yes ☐ No	Emphysema	☐ Yes ☐ No	COPD	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No

Do you use:

Smokeless Tobacco	☐ Yes ☐ No	Cigarettes	☐ Yes ☐ No	Any controlled substance	☐ Yes ☐ No

Are you undergoing, or have you ever had, any of the following Cancer treatments?

Chemotherapy	☐ Yes ☐ No	Radiation	☐ Yes ☐ No	Surgery/Reconstruction	☐ Yes ☐ No

Vision Disorder:

Glaucoma	☐ Yes ☐ No	Cataracts	☐ Yes ☐ No	Diabetic Retinopathy	☐ Yes ☐ No	Blind (	☐ Yes ☐ No
Macular Degeneration	☐ Yes ☐ No						

Hearing Disorder:

Deaf	☐ Yes ☐ No	Hard of hearing	☐ Yes ☐ No	Do you wear hearing aids?	☐ Yes ☐ No

Mental Health Conditions:

Bipolar Disorder	☐ Yes ☐ No	Depression	☐ Yes ☐ No	Anxiety	☐ Yes ☐ No	Schizophrenia	☐ Yes ☐ No

Congenital Disorders:

Spina Bifida	☐ Yes ☐ No	Cerebral Palsy	☐ Yes ☐ No	Down Syndrome	☐ Yes ☐ No
Muscular Dystrophy	☐ Yes ☐ No	Mental or Physical challenges	☐ Yes ☐ No	Aspergers / Autism	☐ Yes ☐ No

Have you ever had any serious illness not listed above? ☐ Yes ☐ No If yes

Signature

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian :

X Date:_____

Please take a few minutes and let us know about your dental history by answering the following questions:

Yes No DK (Don't Know)

☐ ☐ ☐ Are you currently experiencing dental pain or discomfort? If yes, where? _____

☐ ☐ ☐ Are your teeth sensitive to cold, hot, sweets or pressure? (Specify) _____

☐ ☐ ☐ Do you have swelling in or around your mouth, face or neck? (Specify) _____

☐ ☐ ☐ Do you have loose teeth?

☐ ☐ ☐ Do you have headaches, earaches, or neck pain? (Specify)_____ _____

Do you have any clicking, popping, or discomfort in the jaw?

☐ Clicking ☐ Popping ☐ Discomfort

☐ ☐ ☐ Do you clench, brux, or grind your teeth? (Specify)_____

☐ ☐ ☐ Have you had any periodontal (gum) treatment?

☐ ☐ ☐ Do you have bridges or wear dentures or partials? (Specify)_____

Have you had any problems associated with previous dental treatment? Please explain:

_____

How often do you brush your teeth?

☐ Never ☐ Sometimes ☐ Once a day ☐ Twice a day ☐ More than twice a day

How often do you floss your teeth?

☐ Never ☐ Sometimes ☐ Once a day ☐ Twice a day ☐ More than twice a day

Yes No DK (Don't Know)

☐ ☐ ☐ Do your gums bleed when you brush or floss?

☐ ☐ ☐ Do you have any obstacles to cleaning or caring for your teeth?

☐ ☐ ☐ Does food or floss catch between your teeth?

☐ ☐ ☐ Is your mouth dry?

☐ ☐ ☐ Is your home water supply fluoridated?

Do you have a diet high in sugar? If yes, which of the following do you consume more than once a day?
☐ Candy/mints/gum ☐ Coffee/ Tea ☐ Soda pop ☐ Sports drinks ☐ Cough Drops ☐ Other sugary foods

☐ ☐ ☐ Do you participate in active recreational activities or sports?

☐ ☐ ☐ Have you ever had a serious injury to your head or mouth?

☐ ☐ ☐ Are you unhappy with your smile or the appearance of your teeth?

☐ ☐ ☐ Are you worried about losing your teeth?

Have you been told you snore or are you being treated for sleep issues? Yes ☐ No ☐

Rate your fear of dental treatment on a scale of 0 (no fear) to 10 (extreme fear): _____

Please state any questions or concerns about dentistry or your dental health :

_____

Informed Consent of Financial and Appointment Policy

Financial Policy

- You are responsible for all charges incurred by New Image Dentistry
- You are responsible for providing our office staff with all necessary insurance information and we will gladly file your Dental claims; however, we cannot guarantee any estimated coverage
- Payment arrangements for your deductible and coinsurance will be completed prior to treatment

Appointment Policy

- 24-hour notice is appreciated for any cancellation or reschedule of appointments
- Appointments cancelled with a 24-hour notice may be rescheduled
- Failed appointments (appointments cancelled with less than 24 hours notice) may result in dismissal from our practice

As a courtesy, and when time allows, we make reminder calls for appointments. If you do not receive a reminder call or message, the above policy remains in effect. You are responsible for your scheduled appointments.

Authorization

I have read and agree to the terms and conditions listed above and I hereby authorize the release of any dental information necessary to process my dental insurance claim and request payment of benefits to New Image Dentistry.

I understand I am financially responsible to New Image Dentistry for charges not covered or denied by my insurance company. I further agree in the event of non-payment, to pay the cost of collection and / or court costs and reasonable fees should they be required.

I have read and understand the policies as stated to me above.

_____

Patient signature (or parent if minor) Date

HIPAA ACKNOWLEGMENT OF PRIVACY PRACTICE AND RELEASE FORM

I acknowledge that I have been informed of the privacy practices of New Image Dentistry.

Signature of Patient (Parent or Guardian) _____Date _____

Release of Information

I, _____ (Print patient / guardian name), authorize the release of information regarding _____ (Patient name), including the diagnosis, records, examination and treatment rendered to the above patient, ledger and billing, and claims information.

This information may be released to my following family members (check one):

☐ Spouse _____

☐ Child(ren) _____

☐ Other _____

Please note that information released to insurance is authorized by signature on the Patient Information form and is separate from this Release of information document.

In further consideration for this, New Image Dentistry agrees to the same stipulations. This Release of Information will remain in effect until terminated by me in writing.

Messages and communication from our office

I, _____ (Print patient / guardian name), authorize New Image Dentistry to contact me regarding _____ (Patient name), in the following ways:

Check all that apply: ☐ Text ☐ Email ☐ Phone message/Voicemail ☐ US mail