

NEWTON CROSSING DENTAL

Patient Information

Patient Name: _____ Ms. Mr. Mrs. Miss Mstr
 Last, First MI (Preferred Name)

Address: _____
 Apartment# Street

City: _____ Postal Code: _____ Birth Date: (Date/Month/Year) _____

Email Address: _____ Care Card _____ DL _____

Phone: (Home) _____ Work: _____ Ext _____

Cell: _____ Emergency Contact Name: _____ Phone: _____

Health Information

Date of Last Dental Visit: _____ Reason for today's visit: _____

Have you ever had any of the following? **PLEASE CHECK ONLY THOSE APPLY:**

AIDS	Glaucoma	Pregnancy	Penicillin Allergy
Allergies	Growths	Due date: _____	
	Hay Fever	Radiation Treatment	Other
Anemia	Head Injuries	Respiratory Problems	Conditions _____
Arthritis	Heart Disease	Rheumatic Fever	
Artificial Joints	Heart Murmur	Rheumatism	Smoker _____
Asthma	Hepatitis A B C	Sinus Problems	
Blood Disease	High Blood Pressure	Stomach Problems	Medications _____
Cancer	Jaundice	Stroke	
Diabetes	Kidney Disease	Tuberculosis	_____
Dizziness	Liver Disease	Tumors	
Epilepsy	Mental Disorders	Ulcers	
Excessive Bleeding	Nervous Disorders	Venereal Disease	
Fainting	Pacemaker	Codeine Allergy	

• 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: _____

• Name of Physician: _____ Phone: _____

• Do you have any health problems that need further clarification? Yes No
 If yes, please explain: _____

To the best of my knowledge, all of 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.

 Signature of patient, parent or guardian Date: _____

Referral Information

Whom may we thank for referring you to our practice? _____

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? Yes No

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insurance Company Name: _____

Patient's relationship to insured: Self Spouse Child Other _____

Secondary

Name of Insured: _____ Is insured a patient? Yes No

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insurance Company Name: _____

Patient's relationship to insured: Self Spouse Child Other _____

Consent for Services

We do NOT do payment plans, so please be advised that payment is expected in full when services are rendered. Our office also requires 48 hour notice for altering any appointment, If this is not given we do apply a fee to your account.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the plan and that he or she is personally responsible for payment of all dental services not covered by your plan. This office will help prepare the patients insurance forms on your behalf and submit to insurance. However, this dental office cannot render services on the assumption that our charges will be paid by your insurance company

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Dentist, or his assignee, at the time said services are rendered. Further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

Signature of patient, parent or guardian _____ Date _____ Relationship to Patient: _____