Justin Newberry, DDS INC

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Welcome to our Practice

Please take a moment to enter your information to help us ensure the quality of your care is excellent.

Chart#: ____________________
FOR OFFICE USE ONLY

Patient Name: ____________________ ____________________ ___ ____________________
Last First MI Preferred Name

Title: __________ **Gender:** ○ Male ○ Female **Family Status:** ○ Married ○ Single ○ Child ○ Other
Mr/Ms/Mrs/etc

Birth Date: __________ **SS#:** ___-__-____ **Prev. Visit:** __________

Email Address: ____ **Best time to call:** ________________

Phone: ____________ ____________ ____________ ______ ____________ ____________
Home Mobile Work Ext Fax Other

Address: ____ ____
Address 1 Address 2

____ ______ _____-____
City State Zip Code

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

☐ Dental Office ☐ Patient ☐ Internet ☐ Insurance Website ☐ Work
☐ Walk-In ☐ Other

Name of person, office, or other source referring you to our practice:

____

Name and Phone # of person to contact in case of emergency. *

____

____

Spouse or Parent/Guardian Information

The following is for: ○ the patient's spouse ○ the person responsible for payment ○ both ○ neither-not applicable

Name: ______________________ ______________________ ___ _______________
Last First MI Preferred Name

Title: ________ **Gender:** ○ Male ○ Female **Family Status:** ○ Married ○ Single ○ Child ○ Other
Mr/Ms/Mrs/etc

Birth Date: __________ **SS#:** ___-__-____ **DL#:** ____________________

Email Address: ____ **Best time to call:** ______________

Phone: __________ __________ __________ _____ __________ __________
Home Mobile Work Ext Fax Other

Address: ________________________________ ________________________________
Address 1 Address 2

____ ______ _____-____
City State Zip Code

Employment Information

The following is for: ○ the patient ○ the person responsible for payment ○ both ○ not applicable

Employer Name: ____ **Phone:** __________

Employer Address: ____________________________ ____________________________
Address 1 Address 2

____ ______ _____-____
City State Zip Code

Primary Dental Insurance:

Name of Insured: ___________________________ ___________________________ ___
Last First MI

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

Insurance Plan Name: ____

Secondary Dental Insurance:

Name of Insured: ___________________________ ___________________________ ___
Last First MI

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

Insurance Plan Name: ____

☐ * **By initialing this box I understand that I am financially responsible for any outstanding balance for services provided that are not covered by insurance, and I may be billed for this remaining balance.**

Medical & Dental Information

Please take a moment to let us know about your medical and dental history so we may serve you more effectively and in a way that watches out for your overall health and well-being.

Would you consider yourself to be in fairly good health? * ○ Yes ○ No

Within the past year, have there been any changes in your general health? * ○ Yes ○ No

Please mark all of the following with a (Y)es or (N)o response:

- ☐ Have you ever had complications following dental treatment?
- ☐ Are you currently under the care of a physician due to a specific condition?
- ☐ Have you been hospitalized due to a surgery or illness?
- ☐ Are you currently taking any prescription or non-prescription medications?
- ☐ Do you use tobacco (smoking or chewing)?
- ☐ Do you have any other conditions, diseases, etc., not listed above that we should be aware of?
- ☐ Have you ever taken any Bisphosphonates such as Fosamax or Boniva for osteoporosis or had any IV Bisphosphonates for cancer treatment?

Please explain any YES responses.

____

____

Primary Care Physician's name, phone number and medical record number, if applicable. *

____

____

What is the date (or approximate date) of your last medical exam? * ____________________

What is the reason for your dental visit today?

____

____

When was your last visit to the dentist?

____

____

What treatment was performed at your last dental visit?

____

____

Prior Dentist's name, address and telephone number.

____

____

Please mark (Y)es or (N)o to all of the following questions:

- ☐ Do your gums bleed when you brush or floss?
- ☐ Are any of your teeth currently causing you pain or sensitvity to hot or cold?
- ☐ Do you grind your teeth (either consciously or during sleep)?
- ☐ Are any of your teeth loose, or are you concerned about any teeth loosening?
- ☐ Do you currently have any dental implants, dentures, or partials?

If any of the previous questions are marked Yes, please explain:

____

____

If you could change anything about your mouth, teeth, or smile, what would it be?

____

____

____

Medical Information

Please mark all items below with a (Y)es or (N)o and note any health issues/medication not listed in the space below.

____

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☐ Allergies	☐ Anemia	☐ Arthritis	☐ Artificial Joints
☐ Asthma	☐ Blood Disease	☐ Blood Thinners	☐ Blood Transfusion
☐ Cancer/Chemotherapy	☐ Chest Pain	☐ Codeine Allergy	☐ Diabetes
☐ Drug Addiction	☐ Drug Allergy	☐ Epilepsy/Seizures	☐ Erythromycin Allergy
☐ Excessive Bleeding	☐ Fainting	☐ Glaucoma	☐ Head Injuries
☐ Heart Attack	☐ Heart Disease/Murmur	☐ Heart Surgery	☐ Hepatitis
☐ High Blood Pressure	☐ History of Surgery	☐ HIV	☐ Indigestion
☐ Jaundice	☐ Kidney Disease	☐ Liver Disease	☐ Mental Disorders
☐ Pacemaker	☐ Pain in TMJ	☐ Penicillin Allergy	☐ Premedicate
☐ Prosth Heart Valve	☐ Radiation Treatment	☐ Respiratory Problems	☐ Rheumatic Fever
☐ Rheumatism	☐ SEE MED LIST	☐ Sinus Problems	☐ Sleep Apnea
☐ Stroke	☐ Sulfa Allergy	☐ Tobacco Use	☐ Tuberculosis
☐ Tumors	☐ Ulcers	☐ Venereal Disease	

WOMEN ONLY:

- ☐ Are you pregnant or think you are pregnant?
- ☐ Are you nursing?
- ☐ Are you taking oral contraceptives?

Consent for Services and Financial Policy

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid at the time services are performed unless other arrangements are made. Patients with dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services.

This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1.5% per month (18% per annum) on unpaid balances will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.I understand that any fee estimate for dental care can only be extended for a period of six months from the day of the patient examination.

In consideration for the professional services rendered to me by this practice, I agree to pay the charged services rendered at the time of treament, or within (5) days of billing if credit is extended. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due.

APPOINTMENT POLICY- All appointment changes made at least 2 business days in advance of appointment will not be charged a cancellation fee. Appointment changes or cancellations, and failed appointments without 48 hours notice will have an asssessed fee of $50 per half hour.

☐ * **By initialing this box I acknowledge that I understand the above information and agree to it's contents.**

HIPAA Practices

All information that is obtained from you by this office is protected and kept confidential. Every reasonable measure to prevent unauthorized disclosure of your protected health information is practiced.

Uses and Disclosures
Your protected health information is accessed and used for healthcare purposes only.
Your protected health information is never sold, rented, transferred, exchanged, and/or used for non-healthcare related purposes including marketing activities without your prior written authorization.
Your protected health information is disclosed to third-party entities without your written authorization for the purposes of treatment, to obtain payment for treatment, and for healthcare operations.

Patient Rights
You have the right to request in writing to inspect and/or receive a copy of your health information.
You have the right to request an alteranate means or location to receive communications regarding your health information.
You have the right to request in writing to restrict some of the uses and disclosures of your health information.
You have the right to request in writing an accounting of certain disclosures of your health information that were made by this office.

I grant my permission to you or your assignee to telephone me or leave a voicemail regarding my account or treatment.

I acknowledge that I have received or reviewed a copy of the Dental Materials Fact Sheet dated May 2004 as required by law.

☐ * **By initaling this box, I understand the above information and agree with its contents.**

Signature of patient, parent, or guardian:

Signature ______________________________ **Date** _________

Relationship to Patient:

____

____

Provider Signature

Signature ______________________________ **Date** _________

Response Date:
____/____/________