New Patient Registration Form

Patient Information

First Name: Last Name: Middle Initial:

Patient is: ◯ Policy Holder ◯ Responsible Party Preferred Name:

Address:

City: State: Zip:

Home Phone: Work Phone: Cell Phone:

Email Address:

Birth Date: Age: Social Security: Driver's License:

Sex: ◯ Male ◯ Female Marital Status: ◯ Single ◯ Married ◯ Separated ◯ Divorced ◯ Widowed

Employment Status: ◯ Full Time ◯ Part Time ◯ Retired Student Status: ◯ Full Time ◯ Part Time

Occupation:

Responsible Party (If someone other than the patient)

First Name: Last Name: Middle Initial:

Address:

City: State: Zip:

Home Phone: Work Phone: Cell Phone:

Birth Date: Social Security: Driver's License:

Responsible Party is also a Policy Holder ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder ☐

East Madison Dental

New Patient Registration

Primary Insurance Information

Name of Subscriber:

Relationship to Patient: ◯Self ◯Spouse ◯Child ◯Other Subscriber Social Security: Subscriber Birth Date:

Employer:

Address: City: State: Zip:

Insurance Company:

Address: City: State: Zip:

Group #:

Secondary Insurance Information

Name of Subscriber:

Relationship to Patient: ◯ Self ◯Spouse ◯Child ◯ Other Subscriber Social Security: Subscriber Birth Date:

Employer:

Address: City: State: Zip:

Insurance Company:

Address: City: State: Zip:

Group#:

Referral Information

Whom may we thank for referring you to our practice? (check all that apply)

◯ Newspaper ◯ Dental Office ◯ Facebook ◯ Google search ◯ Postcard ◯ Angie's List ◯ EMD Letter ◯ Social Media

Other: Name of person referring you to our practice:

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Medical History

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive.

Thank you for answering the following questions.

Your physician's name: _____

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: _____

Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____

Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____

Are you on a special diet? ◯ Yes ◯ No If yes, please explain: _____

Do you use tobacco? ◯ Yes ◯ No If yes, please explain: _____

Do you use controlled substances? ◯ Yes ◯ No If yes, please explain: _____

Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____

Women: Are You

Healthy? ◯ Yes ◯ No Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking Oral Contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Allergies:

Are you allergic to any of the following: ◯ Aspirin ◯ Penicillin ◯ Codeine ◯ Acrylic ◯ Metal ◯ Latex ◯ Local Anesthetics ◯ Other: _____

If yes, please explain: _____

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

AIDS/HIV Positive ☐ Yes ☐ No	Cortisone Medicine ☐ Yes ☐ No	Heart Trouble/Disease ☐ Yes ☐ No	Reflux ☐ Yes ☐ No
Alzheimer's Disease ☐ Yes ☐ No	Depression ☐ Yes ☐ No	Hemophilia ☐ Yes ☐ No	Renal Dialysis ☐ Yes ☐ No
Anaphylaxis ☐ Yes ☐ No	Diabetes ☐ Yes ☐ No	Hepatitis A, B or C ☐ Yes ☐ No	Rheumatic Fever ☐ Yes ☐ No
Anemia ☐ Yes ☐ No	Drug Addiction ☐ Yes ☐ No	Herpes ☐ Yes ☐ No	Rheumatism ☐ Yes ☐ No
Angina ☐ Yes ☐ No	Dry Mouth/Skin ☐ Yes ☐ No	High Blood Pressure ☐ Yes ☐ No	Scarlet Fever ☐ Yes ☐ No
Anxiety ☐ Yes ☐ No	Easily Winded ☐ Yes ☐ No	Hives or Rash ☐ Yes ☐ No	Shingles ☐ Yes ☐ No
Arthritis/Gout ☐ Yes ☐ No	Emphysema ☐ Yes ☐ No	Hypoglycemia ☐ Yes ☐ No	Sickle Cell Disease ☐ Yes ☐ No
Artificial Heart Valve ☐ Yes ☐ No	Epilepsy or Seizures ☐ Yes ☐ No	Irregular Heartbeat ☐ Yes ☐ No	Sinus Trouble ☐ Yes ☐ No
Artificial Joint ☐ Yes ☐ No	Excessive Bleeding ☐ Yes ☐ No	Kidney Problems ☐ Yes ☐ No	Spina Bifida ☐ Yes ☐ No
Asthma ☐ Yes ☐ No	Excessive Thirst ☐ Yes ☐ No	Leukemia ☐ Yes ☐ No	Stomach/Intestinal Disease ☐ Yes ☐ No
Blood Disease ☐ Yes ☐ No	Fainting Spells/Dizziness ☐ Yes ☐ No	Liver Disease ☐ Yes ☐ No	Stroke ☐ Yes ☐ No
Blood Transfusion ☐ Yes ☐ No	Frequent Cough ☐ Yes ☐ No	Low Blood Pressure ☐ Yes ☐ No	Swelling of Limbs ☐ Yes ☐ No
Breathing Problem ☐ Yes ☐ No	Frequent Diarrhea ☐ Yes ☐ No	Lung Disease ☐ Yes ☐ No	Thyroid Disease ☐ Yes ☐ No
Bruise Easily ☐ Yes ☐ No	Frequent Headaches ☐ Yes ☐ No	Mitral Valve Prolapse ☐ Yes ☐ No	Tonsillitis ☐ Yes ☐ No
Cancer ☐ Yes ☐ No	Genital Herpes ☐ Yes ☐ No	Osteoporosis ☐ Yes ☐ No	Tuberculosis ☐ Yes ☐ No
Chemotherapy ☐ Yes ☐ No	Glaucoma ☐ Yes ☐ No	Pain in Jaw Joints ☐ Yes ☐ No	Tumors or Growths ☐ Yes ☐ No
Chest Pains ☐ Yes ☐ No	Hay Fever ☐ Yes ☐ No	Parathyroid Disease ☐ Yes ☐ No	Ulcers ☐ Yes ☐ No
Cold Sores/Fever Blisters ☐ Yes ☐ No	Heart Attack/Failure ☐ Yes ☐ No	Psychiatric Care ☐ Yes ☐ No	Venereal Disease ☐ Yes ☐ No
Congenital Heart Disease ☐ Yes ☐ No	Heart Murmur ☐ Yes ☐ No	Radiation Treatments ☐ Yes ☐ No	Yellow Jaundice ☐ Yes ☐ No
Convulsions ☐ Yes ☐ No	Heart Pace Maker ☐ Yes ☐ No	Recent Weight Loss ☐ Yes ☐ No	Are you healthy? ☐ Yes ☐ No

Comments:

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 _____ Date _____

Signature of Doctor _____ Date _____

East Madison Dental

101 Piermont Road • Tenafly, NJ 07670 • (201) 501-8282 •
www.emdental.com

Dental History

Patient Name_____ **Medical Alert**_____

What is the reason for your visit today?_____

_____

Date of Last Dental Visit_____ **Last Dental Cleaning**_____ **Last Full Mouth X-rays**_____

What was done at your last dental visit?_____

Previous Dentist's Name_____ Telephone _____

How often do you have dental examinations? _____

How often do you brush your teeth?_____

How often do you floss? _____

Have you ever used or are you currently using topical fluoride? ◯Yes ◯No

What other dental aids do you use? (electric toothbrush, toothpick, etc.) _____

Do you have any dental problems now? ◯Yes ◯No If yes, please describe:_____

Do you feel nervous about having dental treatment? ◯Yes ◯No If yes, please describe: _____

Have you ever had an upsetting dental experience? ◯Yes ◯No If yes, please describe:_____

Have you ever been told to take a pre-medication prior to dental treatment? ◯Yes ◯No

Is there anything else about having dental treatment that you would like us to know? ◯Yes ◯No If yes, please describe: _____

Do you or have you had any of the following?

Orthodontic treatment	☐Yes ☐ No
Oral surgery	☐Yes ☐ No
Periodontal (Gum) treatment	☐Yes ☐ No
Your teeth ground or the bite adjusted	☐Yes ☐ No
A bite plate or mouth guard	☐Yes ☐ No
Clicking or popping of the jaw	☐Yes ☐ No
Pain? (Joint, ear, side of face)	☐Yes ☐ No
No Difficulty in opening or closing the mouth	☐Yes ☐ No
Difficulty in chewing on either side of the mouth	☐Yes ☐ No
Headaches, neck aches or shoulder aches	☐Yes ☐ No
Dry mouth	☐Yes ☐ No
Wear full/partial dentures	☐Yes ☐ No
Need to chew on one side of mouth	☐Yes ☐ No
A serious injury to the mouth or head	☐Yes ☐ No

Please describe, including cause _____

_____

_____

If you could easily change anything about your smile, what would it be? Please check all that apply

◯Whiten teeth
◯Shape of teeth
◯Improve your smile
◯Straighten teeth
◯Replace missing teeth
◯Red or swollen gums

Are any of your teeth sensitive to

Hot, cold or sweets?	☐Yes ☐ No
Biting or Chewing?	☐Yes ☐ No
Have you noticed any mouth odors or bad tastes?	☐Yes ☐ No
Do you frequently get cold sores, blisters or any oral lesions?	☐Yes ☐ No
Do your gums bleed or hurt?	☐Yes ☐ No
Have your parents experienced gum disease or tooth loss?	☐Yes ☐ No
Have you noticed any loose teeth or change in your bite?	☐Yes ☐ No
Does food tend to become caught in between your teeth?	☐Yes ☐ No

Do you:

Clench or grind your teeth while awake or asleep?
Hold foreign objects with your teeth (pencils, pipe, etc.)?
Mouth breathe while awake or asleep?
Have tired jaws, especially in the morning?
Snore or have any other sleeping disorders?
Smoke/chew tobacco or use other tobacco products?

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_____ _____
Signature of Doctor Date

Financial Agreement

Payment is due at the time of treatment. We can accept cash, checks and major credit cards. We also have a payment plan through third party financing; these plans allow you to start treatment today and spread payments over time.

Payment Options:

Please indicate below which form of payment you choose to use: (check one)

◯ Cash ◯ Personal Check ◯ Credit Card ◯ Debit Card ◯ CareCredit®/Lending Club

Authorization, Release and Agreement to Pay for Services Rendered

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such dental care to third-party payers and/or health practitioners.

I authorize and hereby request my insurance company to pay directly to the dentist (or the dental group) insurance benefits otherwise payable to me.

I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or on behalf of my dependents.

Office Policies

- There is a fee of $50.00 for returned checks.
- In the event the use of a collection agency is required, an additional $50.00 will be applied for collections management.
- EMD Guarantee*: Crowns & veneers (100% 1-3 years, 50% 4-5 years) two years on fillings, two years on sealants, two years on night guards (does not cover lost night guards). *Patients must be seen a minimum of two times per year for their routine hygiene maintenance.
- Refunds: CareCredit and Lending Club refunds will be sent back to CareCredit or Lending Club. Cash, check and credit card payments will be refunded via check.
- No Show Fee: If you are unable to keep your appointment, please give us a call 48 hours prior to your appointment to reschedule. If you do not give us advanced notice, there will be a $100 No Show fee.

MY PERSONAL OR FINANCIAL INFORMATION CAN BE SHARED WITH THE FOLLOWING:

◯ SPOUSE ◯ PARENT(s)(Mother/Father) ◯ ADULT CHILD ◯ NO ONE ◯ OTHER_____

_____ _____

Signature of Patient/Responsible Party Date

East Madison Dental

Consents & Notice of Privacy Practices

Text Messages

I, _____, consent to East Madison Dental using my cell phone to (choose one or both) ○ ○
Call or Text regarding appointments and to call regarding treatment, insurance and my account. I understand that I can withdraw my consent at any time.

My cell phone number is (include area code): _____

_____
Signature

Date

Email Communications

I consent to receiving from East Madison Dental email communications regarding treatment, insurance, special promotions and my account. I understand that I can withdraw my consent at any time.

My email address is: _____

_____
Signature Date

Notice of Privacy Practices

You May Refuse to Sign This Acknowledgement

I have received and reviewed a copy of this office's Notice Privacy Practices. our dental practice's privacy, security and breach notification policies and procedures.

I understand that I should ask our dental practice's Privacy Official if I have any questions about these policies and procedures.

Print Name: _____

_____
Signature

Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:
☐ Individual Refused to sign ☐ Emergency Situation ☐ Communications Barrier ☐
Other:_____

East Madison Dental