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

Narpat S. Jain, DMD, FAGD & John H. Sabat, DMD
101 Piermont Road • Tenafly, NJ 07670 • (201) 501-8282 • www.emdental.com

New Patient Insurance Form

MEDICAL Insurance Information

Name of Insured:

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

Employer:

Address: City: State: Zip:

Insurance Company:

Address: City: State: Zip:

Group #:

DENTAL Insurance Information

Name of Insured:

Relationship to Insured: ◯Self ◯Spouse ◯Child ◯Other Insured Social Security: Insured 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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History and Symptoms

Thank you for answering the following questions.

Patient's Name_____

Date of Birth: _____

Patient's Pediatrician: _____

Birth Weight (lb. oz): _____ Current Weight: _____

HAVE YOU NOW OR EVER HAD ANY OF THE FOLLOWING:

Baby's Symptoms:

Poor Latch	◯ Yes	◯ No
Colic symptoms	◯ Yes	◯ No
Gassy	◯ Yes	◯ No
Spitting up	◯ Yes	◯ No
Gumming or chewing on nipple	◯ Yes	◯ No
Unable to hold pacifier	◯ Yes	◯ No
Slides off nipple when latching	◯ Yes	◯ No
Falls asleep during nursing	◯ Yes	◯ No
Feeding takes longer than 20 min.	◯ Yes	◯ No
Ineffective feeding	◯ Yes	◯ No
Family history of Tongue Tie	◯ Yes	◯ No
Family history of Lip Tie	◯ Yes	◯ No
Was your child premature?	◯ Yes	◯ No

Mother's Symptoms:

Creased, flattened nipples	◯ Yes	◯ No
Cracked, bruised nipples	◯ Yes	◯ No
Bleeding nipples	◯ Yes	◯ No
Pain while latching	◯ Yes	◯ No
Poor breast drainage	◯ Yes	◯ No
Infected nipples or breasts	◯ Yes	◯ No
Plugged ducts	◯ Yes	◯ No
Mastitis or nipple thrush	◯ Yes	◯ No

Does your child have any health conditions? YES____ NO_____

If yes, _____.

Has your infant had any surgery? YES____ NO_____

If yes, _____.

Has your child had prior surgery to correct the tongue or lip tie? YES____ NO_____

If yes, when/by whom? _____.

Is your child currently taking any medications? YES____ NO_____

If yes, _____.

Is your child allergic to any medications? YES____ NO_____

If yes, _____.

Doctor's Signature _____ Date _____

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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.

PLEASE DO NOT SHARE MY PERSONAL OR FINANCIAL INFORMATION WITH THE FOLLOWING:

◯ SPOUSE ◯ PARENT(s) (Mother/Father) ◯ ADULT CHILD ◯ OTHER:_____

_____ _____

Signature of Patient/Responsible Party Date

East Madison Dental

Text and Email Consent

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

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

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