Relationship Dentistry
123 Main Street, Suite 200, Your Town, NJ 07000 · (201) 321-9330

RD

New Patient Registration

PATIENT INFORMATION

Last Name _____ First Name _____

Date of Birth _____ Sex _____ Preferred Name _____

Street Address _____

City _____ State _____ ZIP _____

Home Phone _____ Cell Phone _____ Work Phone _____

Email _____

Occupation _____ Employer _____

Marital status:

☐ Single ☐ Married ☐ Divorced
☐ Widowed ☐ Other

How did you hear about us? _____

EMERGENCY CONTACT

Name _____ Relationship _____

Phone _____ Alternate Phone _____

PRIMARY DENTAL INSURANCE

Subscriber Name _____ Subscriber Date of Birth _____

Relationship to Patient _____ Insurance Company _____

Member / Subscriber ID _____ Group Number _____

Employer _____ Insurance Phone _____

SECONDARY DENTAL INSURANCE (IF ANY)

Subscriber Name

Insurance Company

Member ID

Group Number

RESPONSIBLE PARTY (IF OTHER THAN PATIENT)

Name

Relationship

Address

Phone

Date of Birth

Signature of Patient
(or Parent/Guardian)

Date

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Medical History

PATIENT

Patient Name _____ Date of Birth _____

Physician Name _____ Physician Phone _____

Date of Last Physical Exam _____

GENERAL HEALTH

Are you under a physician's care now? ☐ Yes ☐ No

Have you been hospitalized or had major surgery in the past 5 years? ☐ Yes ☐ No

Have you ever had a serious illness or injury? ☐ Yes ☐ No

Are you taking any medications, supplements or vitamins? ☐ Yes ☐ No

Please list all medications _____

Do you use tobacco or vaping products? ☐ Yes ☐ No

Have you ever taken bisphosphonates (Fosamax, Boniva, Prolia, etc.)? ☐ Yes ☐ No

Women: Are you pregnant, trying to become pregnant, or nursing? ☐ Yes ☐ No

ALLERGIES — CHECK ALL THAT APPLY

☐ Penicillin
☐ Amoxicillin
☐ Codeine
☐ Local anesthetics
☐ Latex
☐ Aspirin
☐ Ibuprofen
☐ Sulfa drugs
☐ Metals
☐ Other

Other allergies _____

DO YOU HAVE OR HAVE YOU HAD — CHECK ALL THAT APPLY

☐ Heart disease
☐ Heart attack
☐ High blood pressure
☐ Low blood pressure
☐ Artificial heart valve
☐ Heart murmur
☐ Pacemaker
☐ Stroke
☐ Artificial joint
☐ Diabetes
☐ Asthma
☐ Emphysema / COPD
☐ Kidney disease
☐ Liver disease / Hepatitis
☐ HIV / AIDS
☐ Cancer
☐ Radiation therapy
☐ Chemotherapy
☐ Epilepsy / Seizures
☐ Fainting spells
☐ Thyroid disease
☐ Osteoporosis
☐ Anemia
☐ Bleeding disorder

☐ Sleep apnea
☐ Tuberculosis
☐ Acid reflux / GERD
☐ Anxiety / Depression
☐ Arthritis
☐ Other

Please explain any checked items

I certify that the information above is complete and accurate to the best of my knowledge. I will inform the office of any changes in my health or medications.

Signature of Patient (or Parent/Guardian)

Date

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Dental History

PATIENT

Patient Name _____ Date of Birth _____

Previous Dentist _____ Date of Last Dental Visit _____

Date of Last X-Rays _____ Reason for Today's Visit _____

YOUR MOUTH

Do your gums bleed when you brush or floss?	☐ Yes ☐ No
Are your teeth sensitive to hot, cold or sweets?	☐ Yes ☐ No
Do you grind or clench your teeth?	☐ Yes ☐ No
Do you have jaw pain, clicking or headaches?	☐ Yes ☐ No
Have you had orthodontic treatment (braces or aligners)?	☐ Yes ☐ No
Have you had a bad experience at the dentist?	☐ Yes ☐ No
Do you feel anxious about dental visits?	☐ Yes ☐ No
Do you wear dentures, partials or a night guard?	☐ Yes ☐ No

WHAT WOULD YOU LIKE TO IMPROVE? — CHECK ALL THAT APPLY

☐ Whiter teeth
☐ Straighter teeth
☐ Replace missing teeth
☐ Fix chipped teeth
☐ Fresher breath
☐ Healthier gums
☐ Old fillings replaced
☐ Nothing — just keep me healthy

Anything else we should know? _____

Signature of Patient (or Parent/Guardian) _____ Date _____

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HIPAA Privacy Acknowledgment

NOTICE OF PRIVACY PRACTICES

Relationship Dentistry is required by law to protect the privacy of your health information and to give you our Notice of Privacy Practices, which describes how we may use and disclose your information and your rights regarding it. A copy is available at the front desk and on request.

By signing below, I acknowledge that I have received or been offered a copy of the Notice of Privacy Practices.

COMMUNICATION PREFERENCES

☐ You may leave messages on my home phone

☐ You may leave messages on my cell phone

☐ You may send appointment reminders by text

☐ You may contact me by email

You may discuss my dental care and account with the following people:

Name _____ Relationship _____

Name _____ Relationship _____

Patient Name _____ Date of Birth _____

Signature of Patient (or Parent/Guardian) _____ Date _____

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Financial & Insurance Policy

OUR POLICY

Payment is due at the time of service unless other arrangements are made in advance. We accept cash, major credit cards, HSA/FSA cards and approved financing.

As a courtesy, we will file claims with your dental insurance. Your insurance is a contract between you and your carrier; any amount not paid by insurance within 60 days is the patient's responsibility. Estimates are not a guarantee of payment.

We ask for at least 24 hours' notice to cancel or reschedule. Missed appointments without notice may be subject to a fee.

Balances over 90 days past due may be referred for collection. Returned checks are subject to a fee.

I have read and understand the financial policy above and agree to be responsible for all charges for services provided to me or my dependents.

Patient Name

Responsible Party

Signature of Patient (or Parent/Guardian)

Date

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General Consent for Treatment

CONSENT

I authorize the dentists and staff of Relationship Dentistry to perform examinations, take X-rays and photographs, provide cleanings, and administer local anesthetic as needed for diagnosis and routine care.

I understand that any further treatment will be explained to me, including its benefits, risks and alternatives, and that I may ask questions and refuse treatment at any time. Separate written consent will be obtained for surgical or complex procedures.

I understand that dentistry is not an exact science and that no guarantee of results has been made.

Is the patient a minor (under 18)? ☐ Yes ☐ No

Parent / Guardian Name (if minor) _____

Relationship to Patient _____

Patient Name _____

Date of Birth _____

Signature of Patient (or Parent/Guardian) _____

Date _____

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Records Release Authorization

PATIENT

Patient Name _____ Date of Birth _____

Phone _____ Email _____

TRANSFER

☐ Send my records FROM the office below TO Relationship Dentistry

☐ Send my records FROM Relationship Dentistry TO the office below

Other Office Name _____

Address _____

Phone _____ Fax / Email _____

RECORDS TO RELEASE

☐ X-rays
☐ Treatment notes
☐ Periodontal charting
☐ Treatment plan
☐ Complete record
☐ Other

Purpose of release _____ Authorization expires on _____

I understand I may revoke this authorization in writing at any time, except to the extent action has already been taken.

Signature of Patient (or Parent/Guardian) _____ Date _____