New Patient Forms

New Patient Information

If you have not yet made an appointment with our office, please call or email us as soon as possible!

Thank you for your interest in becoming a new patient at Dental@888! We're excited to meet you. To make your first appointment as patient focused as possible, we ask that you fill out these forms prior to your scheduled appointment time. Simply hit submit at the end of this form and we will receive your responses. You may also download a copy for your own records.

Patient First Name	
Patient Last Name	
Preferred Name	
Gender	
Social Security number	
Patient Date of Birth	**Mobile Phone**
Other Phone	**E-mail Address**
Address	
Apt #	
City	
State	**Zipcode**
Employer	
Emergency Contact	
How did you hear about our practice?	

Dental Insurance Information

Insurance Options	
Subscriber's First Name	
Subscriber's Last Name	**Subscriber's Date of Birth**
Primary Insurance Carrier	
Subscriber or Member ID	**Group Name**
Group Number	**Insurance Carrier's Phone**
Insurance Carrier's Address	
Do you have a secondary insurance plan?	
Subscriber's First Name	
Subscriber's Last Name	**Subscriber's Date of Birth**
Secondary Insurance Carrier	
Subscriber or Member ID	**Group Name**
Group Number	**Insurance Carrier's Phone**
Insurance Carrier's Address	

Medical History Information

Primary Care Physician
Medications
Allergies

Please check all conditions that apply:

❑ Allergies	❑ Anemia	❑ Arthritis	❑ Artificial Heart Valve
❑ Artificial Joints	❑ Asthma or Respiratory Problems	❑ Bleeding Problems or Blood Thinners	❑ History of Bisphosphonate Use
❑ Blood Disease	❑ Cancer	❑ History of Radiation	❑ Diabetes
❑ Dizziness or Fainting	❑ Epilepsy	❑ Glaucoma	❑ Head Injuries
❑ Heart Disease	❑ Heart Murmur	❑ Hepatitis	❑ High Blood Pressure
❑ HIV	❑ History of Drug or Alcohol Abuse	❑ History of/or Currently Smoking	❑ Jaundice
❑ Kidney Disease	❑ Liver Disease	❑ Mental Health Conditions	❑ Nervous Disorders
❑ Pacemaker	❑ Rheumatism	❑ Sinus Problems	❑ Stomach Problems or Ulcers
❑ Stroke	❑ Thyroid Condition	❑ Tuberculosis	❑ Tumors
❑ *NONE OF THESE CONDITIONS APPLY	❑ *OTHER		

Any OTHER conditions not listed above?

Dental History Information

Previous Dental Visit
Immediate Concerns
Dental Office Comfort

Have you ever experienced any of the following?

Had an unfavorable dental experience	❑ Yes	❑ No	**Complications following a dental procedure**	❑ Yes	❑ No
Sensitive gag reflex	❑ Yes	❑ No	**Food getting caught between your teeth**	❑ Yes	❑ No
Problems chewing	❑ Yes	❑ No	**Gums that bleed from flossing or brushing**	❑ Yes	❑ No
Treatment for gum disease or had a 'deep cleaning'	❑ Yes	❑ No	**Sensitivities to temperature**	❑ Yes	❑ No
Notice clenching or grinding	❑ Yes	❑ No	**Problems with jaw or joint**	❑ Yes	❑ No

Please answer yes or no regarding the appearance of your smile.

Are you currently in Orthodontic treatment, such as braces or aligners?	❑ Yes	❑ No	**Do you currently wear an appliance such as a night guard?**	❑ Yes	❑ No
Have you ever, or are you interested in, straightening your teeth?	❑ Yes	❑ No	**Have you ever, or are you interested in, bleaching or whitening your teeth?**	❑ Yes	❑ No

Financial Policy and HIPAA Acknowledgement

Financial Policy

Whether there is dental insurance or not, the patient is responsible for all charges and fees of service incurred. If you have dental insurance, we will happily estimate what your patient-share (co-payment) will be for treatment to be rendered. That portion will be due at the time of service.

We accept: Cash, Check, Discover, Visa and Mastercard.

We will bill your insurance company for the estimated balance. We estimate in good faith what we expect your insurance company to pay toward your treatment. If the insurance payment is less than anticipated, any difference will be patient's responsibility.

We reserve time exclusively for you and the dental professional. We respectfully request that you honor your appointment. If you need to change your appointment for any reason, a minimum of two full business days (48 hours) notice is required to avoid a charge. Please keep in mind that our business days are from Monday to Thursday.

The short-notice or missed appointment fee is $50 for every thirty minutes scheduled.

HIPAA Acknowledgement

I understand that I may inspect or copy the protected health information described by this authorization.

I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form.

I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

By signing, I understand the above information and agree to the terms as stated.

Today's Date