JOEL NEWTON D.D.S., P.A. - REGISTRATION FORM

Referred by: _____

PATIENT NAME: _____SEX: _____
LAST FIRST MIDDLE M/F
BIRTH DATE: _____ AGE: _____ SOCIAL SECURITY #_____-_____-_____
MARITAL STATUS: _____ DL#_____
MARRIED/SINGLE/DIVORCED/WIDOW
HOME PHONE #_____ Cell#_____
HOME ADDRESS: _____CITY: _____STATE: _____ ZIP: _____
MAILING ADDRESS: _____ CITY: _____STATE: _____ZIP: _____
EMPLOYER NAME: _____ EMPLOYER PHONE #: _____
EMPLOYER ADDRESS: _____CITY: _____STATE: _____ZIP: _____
E-MAIL ADDRESS: _____

SPOUSE/PARENT/LEGAL GUARDIAN INFORMATION

NAME: _____ SEX: _____
LAST FIRST MIDDLE M/F
HOME PHONE #: _____Cell#_____
BIRTH DATE: _____ AGE: _____ SOCIAL SECURITY #_____-_____-_____
HOME ADDRESS: _____CITY: _____STATE: _____ ZIP: _____
MAILING ADDRESS: _____ CITY: _____STATE: _____ZIP: _____
EMPLOYER NAME: _____ EMPLOYER PHONE #: _____
EMPLOYER ADDRESS: _____CITY: _____STATE: _____ZIP: _____

EMERGENCY CONTACT

(NEAREST FRIEND/CLOSEST RELATIVE **"NOT LIVING WITH YOU**")

NAME: _____RELATIONSHIP TO YOU: _____
HOME PHONE #: _____CELL #: _____WORK #: _____

DENTAL INSURANCE INFORMATION

DO YOU HAVE DENTAL INSURANCE? **YES/ NO**
IF YES, PLEASE GIVE DENTAL INSURANCE CARD TO RECEPTIONIST.
PLEASE BE ADVISED **WE <u>DO NOT</u> ACCEPT MEDICARE, MEDICAID OR IDAHO SMILES**.
FINANCIAL OPTIONS ARE AVAILABLE UPON REQUEST

Please be mindful of the hard work, diligence and time taken to schedule your appointment and give us a 24-hour notice if you need to cancel any future appointments. The first no-show, we will warn you. The second no-show you will have to leave a non-refundable deposit to reschedule.

The information above is accurate and complete to the best of my knowledge and is only for the use in my or my dependent's treatment, billing and processing the claim form for my insurance benefits for which I am entitled. I will not hold Dr. Newton or his staff responsible for any errors or omissions that I may have made in the completion of this form.

X_____ DATE: _____
SIGNATURE OF PATIENT/PARENT/LEGAL GUARDIAN (IF A MINOR)

MEDICAL HISTORY

PREFERED PATIENT NAME: _____ DOB: _____
PREFERRED PHARMACY: _____ PHONE #: _____
PHYSICIAN'S NAME: _____PHONE#: _____
DATE OF LAST PHYSICAL: _____

HAS THE PATIENT EVER HAD ANY OF THE FOLLOWING?
(PLEASE CHECK ALL THAT APPPLY)

- **HIGH BLOOD PRESSURE**
- **LOW BLOOD PRESSURE**
- **RADIATION TREATMENT**
- **ARTIFICIAL HEART VALVES**
- **ARTIFICIAL JOINTS**
- **RECENT WEIGHT LOSS**
- **BACK PROBLEMS**
- **DIABETES**
- **RESPIRATORY DISEASE**
- **EPILEPSY**
- **HEADACHES**
- **HEPATITIS**
- **LIVER DISEASE**
- **CANCER**
- **ALLERGIES TO ANESTHETICS**
- **ALLERGIES TO MEDICINE OR DRUGS**
- **GENERAL ALLERGIES**
- **BLOOD DISEASE**
- **ARTHRITIS**
- **TUBERCULOSIS**
- **SWOLLEN NECK OR GLANDS**
- **ASTHMA**
- **SINUS INFECTION**
- **AIDS/HIV**
- **THYROID DISEASE**
- **STROKE**
- **ULCER**
- **VENEREAL DISEASE**
- **CHEMICAL DEPENDENCY**
- **OSTEOPOROSIS**

Do you have a family history of diabetes? Yes/No, if yes please explain: _____
_____

Please review the following medications, if you are receiving any of the following currently or have received them in the past through I.V (most typical for cancer patients), please notify us and check the box next to the medication that applies to you.

☐ **Boniva** ☐ **Aredia** ☐ **Zometa/Zoledronate** ☐ **Bonefos**

IF YOU CHECKED **YES TO DRUG ALLERGIES**, PLEASE LIST ALL MEDICATIONS THE PATIENT IS ALLERGIC TO:

_____ _____
_____ _____
_____ _____

IS THE PATIENT TAKING MEDICATION AT THIS TIME? **YES/NO** IF YES, PLEASE LIST THE MEDICATIONS.

_____ _____
_____ _____
_____ _____

IS THE PATIENT UNDER THE CARE OF A PHYSICIAN? **YES/NO** IF YOU CIRCLED YES, PLEASE EXPLAIN:

_____
_____

WEIGHT OF PATIENT **(IF A CHILD)**: _____
WOMEN ONLY - (IF PATIENT)
ARE YOU PREGNANT? **YES/NO**
ARE YOU NURSING? **YES/NO**
FIRST DAY OF YOUR LAST MENSTRUAL CYCLE: _____

DENTAL HISTORY

(PLEASE CHECK OR CIRCLE ALL THAT APPLY)

1. WHEN DID YOU LAST HAVE YOUR TEETH CLEANED? _____
DATE
2. HAVE YOU EVER SEEN A PERIODONTIST? **YES/NO**
IF YES, WHAT TREATMENT WAS PERFORMED: _____

3. ARE YOU CURRENTLY IN PAIN? **YES/NO**
IF YES, WHEN DID THE PAIN START? _____

4. DO YOUR GUMS BLEED WHEN YOU BRUSH? **YES/NO**
IF YES, HAVE THEY ALWAYS BLED? **YES/NO**

5. ARE YOUR TEETH SENSITIVE TO: (PLEASE CHECK ALL THAT APPLY)

COLD____ HOT____ SWEETS ____ BITING ____

6. DO YOU CLENCH/GRIND YOUR TEETH? **YES/NO**
ONLY WITH STRESS? **YES/NO**

7. ARE ANY OF YOUR TEETH LOOSE? **YES/NO**

8. ARE THERE SPACES FORMING BETWEEN YOUR TEETH? **YES/NO**

9. HAVE YOU EVER HAD ORTHODONTIC TREATMENT? **YES/NO**

10. DO YOU USE TOBACCO PRODUCTS? **YES/NO**
IF YES, WHAT TYPE? _____ HOW MUCH? _____

I, _____, CONFIRM THAT ALL THE MEDICAL HISTORY INFORMATION I PROVIDED IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE. I WILL NOT HOLD DR. NEWTON OR HIS STAFF RESPONSIBLE FOR ANY ERRORS OR OMISSIONS THAT I MAY HAVE MADE IN THE COMPLETION OF THIS FORM.

X_____ DATE: _____
SIGNATURE OF PATIENT/PARENT/LEGAL GUARDIAN (IF A MINOR)

Please continue to next page>>

FINANCIAL AGREEMENT

Thank you for calling our office and scheduling you first exam with Dr. Joel Newton. Your dentist, physician or other health care provider feels it is pertinent for your oral health needs. We appreciate you for choosing our office to treat you. Our mission is to treat you with the highest degree of clinical and ethical standards and make your visit a pleasant experience.

Payment for treatment is necessary for any business or practice and must be defined so that there are no misunderstandings when it comes to this issue. We want your visits to be as beneficial and educational as possible. Our financial agreement is outlined below. If you don't completely understand this agreement, please feel free to ask the receptionist for clarification before signing.

Payment Requirements

Unfortunately, dental benefits do not cover all procedures. Benefit plans vary and may, or may not, completely cover services rendered by Dr. Newton. **If you have benefits with an insurance carrier, it is your responsibility to provide our office with your insurance card and information at your first visit.** This information will be entered into our system and we will file your claim with your benefit carrier. Your first exam will need to be paid in full along with any additional necessary x-rays, vitality test and any prescriptions given.

If you have a benefit plan and need treatment, we are happy to provide you with payment options. Our office requires that you pay at least 50% for each treatment on the day of your appointment. You will be required to sign a financial agreement with our receptionist. If your benefits provider does not directly notify our office of payments made for you, you will be responsible for interest and penalties incurred.

If you do not have any benefits and need treatment, we will provide payment options better than Care Credit. However, our office requires a down payment for each treatment on the day of your appointment. You will be required to sign a financial agreement with our receptionist.

Please note: All account balances that are **not paid in full after 180 days will be settled by legal action** with additional service charges. There will be an interest charge of 1.5% per month and added to your account balance, if greater than 30 days from your treatment date.

WE ACCEPT CASH, CHECKS, AND ALL MAJOR CREDIT CARDS

PRIVATE BENEFIT PLAN INQUIRIES THROUGH YOUR INSURANCE CARRIER ARE YOUR RESPONSIBILITY!
It is your responsibility to know your benefits and what they will or will not cover. The treatment plan given to you at the end of your evaluation will contain all the necessary information you need. A pre-determination can be sent to your benefit provider.

We value your business. If you have any questions about this agreement or your treatment, please be sure, to ask at the time of your visit. It is important to us that you understand the value of your treatment and feel good about your oral health. We look forward to developing a caring, healthy, happy relationship with you.

BY SIGNING BELOW, I AM CONSENTING THAT I HAVE READ AND UNDERSTOOD THE FINANCIAL AGREEMENT ABOVE. I HAVE ASKED ANY QUESTIONS I MAY HAVE, SO THAT I CLEARLY UNDERSTAND MY OBLIGATION TO DR. NEWTON IN PAYING FOR THE SERVICES RENDERED TO ME.

X_____ DATE: _____

SIGNATURE OF PATIENT/PARENT/LEGAL GUARDIAN (IF A MINOR)

RELEASE OF INFORMATION

I, _____, hereby authorize the release of any information relating to all claims and/or records requested by my primary dentist or insurance company on behalf of myself and/or dependents. I understand this authorizes the release of a full report of examination findings, diagnosis, treatment program, etc. I further agree and acknowledge that my signature on this document authorizes Joel Newton D.D.S., P.A. or his staff to submit information requested without obtaining my signature on each and every document requested on myself and/or dependents. I clearly understand that I am bound to this agreement by signing this document as though I had personally signed each authorization in its original form. I understand that this authorization may be revoked by written notice from me to Joel Newton D.D.S., P.A. and/or his staff requesting RELEASE OF INFORMATION AUTHORIZATION be null and void.

IF YOU WOULD LIKE YOUR FAMILY TO HAVE ACCESS TO YOUR MEDICAL/BILLING INFORMATION, PLEASE LIST THEM BELOW:

_____ _____
_____ _____
_____ _____
_____ _____

Please check the option that applies:

_____ I am signing this agreement on behalf of myself.

_____I am signing this agreement on behalf of my dependent that I am legally the parent and/or guardian.

X_____ DATE: _____

SIGNATURE OF PATIENT/PARENT/LEGAL GUARDIAN (IF A MINOR)

PRIVACY STATEMENT

PLEASE READ OUR PRIVACY STATEMENT ENCLOSED WITH YOUR REGISTRATION FORMS

My signature below represents I have read and have been provided a copy of the Joel Newton D.D.S., P.A.- Privacy Statement for my records and have understood the contents.

X_____ DATE: _____

SIGNATURE OF PATIENT/PARENT/LEGAL GUARDIAN (IF A MINOR)

JOEL NEWTON D.D.S., P.A. - PRIVACY STATEMENT

First, we would like to thank you for trusting us with your health care. We would like to define a few terms for you so that you can fully understand our privacy policy.

We will use the words "you" and "your" that will reference to Dr. Newton's patient and/or their parent/guardian. We will use "we" or "our" which will reference Dr. Newton of his staff. Non-public information means; information about you that we gather in connection to provide treatment to you, for your periodontal care.

THE INFORMATION WE COLLECT

We collect non-public personal information about you from the following sources:

- YOUR PATIENT REGISTRATION AND MEDICAL HISTORY FORM
- YOUR GENERAL DENTIST CHART NOTES
- IN CONVERSATION WITH YOU ABOUT YOUR TREATMENT PLAN
- ANY OTHER MEDICAL PROVIDER INFORMATION AS NEEDED

OUR POLICY

We do not disclose any non-public personal information about you to anyone that is not permitted by law or authorized by you. We restrict access to our patient's personal chart and electronic information to those that are not authorized to have your non-public personal information.

If you have any concerns about your privacy, please do not hesitate to state them to us at your visit. Thank you for your confidence in our office.

JOEL NEWTON D.D.S., P.A.
2064 WASHINGTON ST. N. – TWIN FALLS, IDAHO 83301
208-734-1515