



New Patient Packet

Patient Information

Patient First Name:	Middle Name:	Last Name:	Address:		
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>		
City:	State:	Zip Code:	Driver's License #:	Date of Birth:	SSN #:*
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Email:	Gender:	Marital Status:	Cell Phone:	Home Phone:	Work Phone:
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Emergency Contact Name:	Number:	Relationship :			
<input type="text"/>	<input type="text"/>	<input type="text"/>			

Dental Insurance

Policy Holder's First Name:	Policy Holder's Last Name:	Policy Holder's DOB:	Policy Holder's SSN #:
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Your Relationship to Policy Holder:	Employer:	Insurance Company Name:	Phone #:
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Subscriber ID:	Group #:	Insurance Card - Front No File Uploaded	Insurance Card - Back No File Uploaded
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Drivers License or ID card No File Uploaded			

Medical History

Are you under a physician's care now? ☐ Yes ☐ No	If Yes, <input type="text"/>	Have you ever been hospitalized or had a major operation? ☐ Yes ☐ No	If Yes, <input type="text"/>
Have you ever had a serious head or neck injury? ☐ Yes ☐ No	If Yes, <input type="text"/>	Are you allergic to any of the following: ☐ Aspirin ☐ Metal ☐ Penicillin ☐ Latex ☐ Codeine ☐ Sulfa Drugs ☐ Acrylic ☐ Local Anesthetic	
Other Allergies List Here: <input type="text"/>			
Are you currently taking any medications?			
Medication Name: <input type="text"/>	Comments/Dosage: <input type="text"/>		
List Medications below: <input type="text"/>	Do you take or have you taken Phen-Fen or Redux?		

Have you ever taken Fosamax Boniva Actonel or any other medications containing bisphosphonates?

- ☐ Yes
- ☐ No

- ☐ Yes
- ☐ No

Do you have or have you had any of the following?

- ☐ AIDS/HIV +
- ☐ Alzheimers Disease
- ☐ Anaphylaxis
- ☐ Anemia
- ☐ Angina
- ☐ Arthritis/Gout
- ☐ Artificial Heart Valve
- ☐ Artificial Joint
- ☐ Asthma
- ☐ Blood Disease
- ☐ Blood Transfusion
- ☐ Breathing Problems
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Chest Pains
- ☐ Cold Sores/Fever Blisters
- ☐ Congenital Heart Disorder
- ☐ Convulsions
- ☐ Yellow Jaundice
- ☐ Cortisone medicine
- ☐ Diabetes
- ☐ Drug Addiction
- ☐ Easily Winded
- ☐ Emphysema
- ☐ Epilepsy or Seizures
- ☐ Excessive Bleeding
- ☐ Excessive Thirst
- ☐ Fainting Spells/ Dizziness
- ☐ Frequent Cough
- ☐ Frequent Diarrhea
- ☐ Frequent Headaches
- ☐ Genital Herpes
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Heart Attack/Failure
- ☐ Heart Murmur
- ☐ Heart Pacemaker
- ☐ Heart Trouble/Disease
- ☐ Hemophillia
- ☐ Hepatitis A
- ☐ Hepatitis B or C
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Hives or Rash
- ☐ Hypoglycemia
- ☐ Irregular Heartbeat
- ☐ Kidney Problems
- ☐ Leukemia
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Lung Disease
- ☐ Mitral Valve Prolapse
- ☐ Osteoporosis
- ☐ Pain in Jaw Joints
- ☐ Parathyroid Disease
- ☐ Psychiatric Care
- ☐ Radiation Treatments

- ☐ Recent Weightloss
- ☐ Renal Dialysis
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Scarlet Fever
- ☐ Shingles
- ☐ Sickle Cell Disease
- ☐ Sinus Trouble
- ☐ Spina Bifida
- ☐ Stomach/Intestinal Disease
- ☐ Stroke
- ☐ Swelling of the Limbs
- ☐ Thyroid Disease
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Tumors or Growths
- ☐ Ulcers
- ☐ Venereal Disease

Please list any serious illness not listed above:

Do you use controlled substances? If Yes, _____

☐ Yes

☐ No

Are you on a special diet? Do you use tobacco?

☐ Yes ☐ Yes

☐ No ☐ No

Women: Are you...

☐ Taking oral contraceptives?

☐ Nursing?

☐ Pregnant/Trying to get pregnant?

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:

Sign

Dental History

Name, address, and phone number of previous dentist:

When was your last dental exam and x-rays?

How did you find us?

☐ Other Patient

☐ Friend/Colleague

☐ Internet

☐ Other

If you selected other patient, please name the patient here:

Reason for today's visit:

☐ Check-up

☐ Pain

☐ Other

What is your immediate dental concern?

Have you ever had a bad experience at the dentist?

☐ Yes

☐ No

If yes, please explain:

Have you had any complications following treatment?

☐ Yes

☐ No

If yes, please explain:

Have you had any unfavorable reactions to dental anesthetic?

☐ Yes

☐ No

If yes, please explain:

Are your teeth sensitive to cold or hot temperatures? Do you grind your teeth?

☐ Yes ☐ Yes

☐ No ☐ No

Are you aware of sores or irritated areas in the mouth? Have you ever been treated for Periodontal or Gum Disease?

☐ Yes ☐ Yes

☐ No ☐ No

Does dental treatment make you nervous?

☐ No

☐ Yes or Slightly

☐ Yes or Moderately

☐ Yes or Extremely

How often do you floss?

☐ Never

☐ Occasionally

☐ Once a day

☐ Twice a day

☐ Three times a day

☐ Every time I eat

I am interested in:

☐ Teeth whitening

☐ Straight teeth

☐ Replacement of missing teeth

Do your gums bleed when you brush or floss?

☐ Yes

☐ No

☐ Sometime

How would you rate the condition of your mouth?

☐ Poor

☐ Good

☐ Excellent

How often do you brush?

☐ Never

☐ Occasionally

☐ Once a day

☐ Twice a day

☐ Three times a day

☐ Every time I eat

What type of brush do you use?

☐ Manual

☐ Electric

☐ Both

Do you like your smile?

☐ Yes

☐ No

To ensure your visit is a great experience, please share any questions or concerns you would like us to know about:

NOTICE OF PRIVACY PRACTICES

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we’ve shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers’ compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address
- We will say “yes” to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say “no” if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say “yes” unless a law requires us to share that information.

Get a list of those with whom we’ve shared information

- You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

• You can complain if you feel we have violated your rights by contacting us using the information on page 1. • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. • We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions. In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you. Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary. Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities. Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

SUD Treatment Information

If we receive or maintain any information about you from a substance use disorder treatment program that is covered by 42 CFR Part 2 (a "Part 2 Program") through a general consent you provide to the Part 2 Program to use and disclose the Part 2 Program record for purposes of treatment, payment or health care operations, we may use and disclose your Part 2 Program record for treatment, payment and health care operations purposes as described in this Notice. If we receive or maintain your Part 2 Program record through specific consent you provide to us or another third party, we will use and disclose your Part 2 Program record only as expressly permitted by you in your consent as provided to us. In no event will we use or disclose your Part 2 Program record, or testimony that describes the information contained in your Part 2 Program record, in any civil, criminal, administrative, or legislative proceedings by any Federal, State, or local authority, against you, unless authorized by your consent or the order of a court after it provides you notice of the court order.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

• We are required by law to maintain the privacy and security of your protected health information • We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. • We must follow the duties and privacy practices described in this notice and give you a copy of it. • We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Other Instructions for Notice

• This statement is effective as of 02/17/2026. • We never market or sell personal information. • We will never share any protected health records without your written permission.

Consent for Use and Disclosure of Protected Health Information

SECTION A: PATIENT GIVING CONSENT

☐ Initial Acknowledgement of Privacy Practices

SECTION B: TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent:

By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

☐ I have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature:

Sign

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: Relationship to Patient:

Stop. ONLY complete Section C if you do not Consent.

SECTION C: RIGHT TO REVOKE: Please read carefully before signing

Right to Revoke:

You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

Signature:

Sign

If this Revoke of Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: Relationship to Patient:

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT. Include completed Consent in the patient’s chart.

Financial Policy

• PATIENT'S ESTIMATED PAYMENT IS DUE AT TIME OF SERVICE. • WE ACCEPT CASH, CHECKS, AMERICAN EXPRESS, VISA, MASTER CARD, DISCOVER, CHERRY FINANCING, and CARE CREDIT.

Insurance: Coverage and Co-pays

We provide insurance company billing as a courtesy to our patients. The patient portion of particular dental service(s) is estimated and due at the time of service. This amount may be subject to adjustment when the dental service(s) claim(s) are adjudicated by the insurance company. In addition, certain insurance companies have annual limitation for the amount of dental services that can be reimbursed within each plan year. If you or your family exceed these annual limitations in any plan year, you will be responsible for the full amount of dental services that exceed the particular plan’s limitations. The patient is responsible for monitoring the amount of his/her remaining benefits for any annual benefit period. The patient may not rely upon any information provided by our team regarding his/her remaining benefit in any such benefit period. For covered services, all co-pays and deductibles must be paid on the day of treatment. Since your insurance company may not cover all costs, we require that you pay any percentage of your balance not paid by your insurance on the day of treatment. For services that are not covered by your insurance, we require that you pay the entire fee the day of your treatment We will attempt to answer any questions we can about your insurance and, to the extent practicable, assist you with insurance billing issues. However, your insurance contract is an agreement between you and your insurance carrier to which we are not a party. In the event that your insurance company does not pay any amounts due for your care, you agree you are financially responsible for such amounts, and that you will pay such amounts due for your care.

Patients Without Insurance

For patients without insurance coverage, you will be responsible for payment on the day of treatment. If you are not able to pay in full, or if your treatment requires several visits, you will be issued an invoice and will be able to discuss payment arrangements with a member of our business office staff.

Cancellation/No Show Policy

Our office requires at least 48 hours advance notice to cancel your appointment in the case of an emergency. *We reserve the right to charge a reasonable fee, up to the amount normally due for our services, for patients who do not give advance notice to cancel an appointment.

Collections

A charge will be added to your account for any returned checks. You are responsible to pay all costs of collecting, or attempting to collect any debt owed on your account including all attorneys' fees, interest, and late fees.

Thank you for understanding and accepting our Financial Policy. Please let us know if you have any questions or concerns.

Responsible Party Signature:

Sign