MIDTOWN SMILES

NEW PATIENT REGISTRATION

Patient Information *(To enable us to effectively care for you, please fill out the form completely.)*

Patient Name _____ Date of Birth _____

Address _____ City _____ State _____ Zip _____

Cell phone _____ Home Phone _____ Message Phone _____

Email _____ Contact Pref. ☐ Text Msg. ☐ Email ☐ Home ☐ Work ☐ Cell

Sex ☐ Male ☐ Female Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Social Security Number _____ Employer _____ Phone Number _____

Responsible Party *(if patient is a minor)*

Name _____ Relationship to Patient _____ ☐ Same Address

Address _____ City _____ State _____ Zip _____

Cell phone _____ Home Phone _____ Work Phone _____

Social Security Number _____ Date of Birth _____

Whom may we thank for referring you to our office? _____

What influenced your decision to choose our practice for your dental needs? _____

Primary Dental Insurance Information

Name of Insured _____ Relationship to Patient _____

Date of Birth _____ Social Security Number _____

Employer _____ Phone Number _____ Extension _____

Employer Address _____ City _____ State _____ Zip _____

Insurance Company _____ Phone Number _____

Ins. Co. Address _____ City _____ State _____ Zip _____

Secondary Dental Insurance Information

Name of Insured _____ Relationship to Patient _____

Date of Birth _____ Social Security Number _____

Employer _____ Phone Number _____ Extension _____

Employer Address _____ City _____ State _____ Zip _____

Insurance Company _____ Phone Number _____

Ins. Co. Address _____ City _____ State _____ Zip _____

MIDTOWN SMILES

HEALTH HISTORY

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

Have you ever been hospitalized or had a major operation? ☐ Yes ☐ No If yes _____

Have you ever had a serious head or neck injury? ☐ Yes ☐ No If yes _____

Are you taking any medications, pills or drugs? ☐ Yes ☐ No If yes _____

Do you take, or have you taken, Phen-Fen or Redux? ☐ Yes ☐ No If yes _____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ☐ Yes ☐ No If yes _____

Are you on a special diet? ☐ Yes ☐ No If yes _____

Do you use tobacco? ☐ Yes ☐ No If yes _____

Do you use controlled substances? ☐ Yes ☐ No If yes _____

Women, are you... ☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives? ☐ N/A

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Other _____

☐ Metal ☐ Latex ☐ Sulfa ☐ Local Anesthetics ☐ No Known Allergies

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

☐ AIDS/HIV Positive
☐ Alzheimer's 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
☐ Cortisone Medications
☐ Diabetes
☐ Drug Addiction
☐ Easily Winded
☐ Emphysema
☐ Epilepsy or Seizures
☐ Excessive Bleeding
☐ Excessive Thirst
☐ Fainting Spells/Dizziness
☐ Frequent Cough
☐ Frequent Diarrhea
☐ Frequent Headaches
☐ Genital Herpes
☐ Hay Fever
☐ Heart Attack/Failure
☐ Heart Murmur*
☐ Heart Pacemaker*
☐ Heart Trouble/Disease
☐ Hemophilia
☐ 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*
☐ Pain in Jaw Joints
☐ Parathyroid Disease
☐ Psychiatric Care
☐ Radiation Treatments
☐ Recent Weight Loss
☐ Renal Dialysis
☐ Rheumatic Fever*
☐ Rheumatism
☐ Scarlet Fever
☐ Shingles
☐ Sickle Cell Disease
☐ Sinus Trouble
☐ Spina Bifida
☐ Stomach/Intestinal Disease
☐ Stroke
☐ Swelling of Limbs
☐ Thyroid Disease
☐ Tonsillitis
☐ Tuberculosis
☐ Tumors or Growths
☐ Ulcers
☐ Venereal Disease
☐ Yellow Jaundice

*Is medication required before your dental visit? ☐ Yes ☐ No

Have you ever had any serious illness not listed above? ☐ Yes ☐ No If yes _____

Comments _____

Family members seen by us _____

Previous / Present Dentist _____ Last Visit Date (Dental Exam / Cleaning) _____

Reason for your visit today _____ Are you currently in pain? ☐ Yes ☐ No For how long? _____

Emergency Contact (besides members of household) _____ Contact Phone _____

PAYMENT/CO-PAYMENT IS DUE IN FULL AT THE TIME OF TREATMENT

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 of PATIENT, PARENT or GUARDIAN _____ Date _____

MIDTOWN SMILES

FINANCIAL AGREEMENTS, CANCELLATION POLICY & NOTICE OF PRIVACY POLICY

Personal Information

Name: _____ Date of Birth: ____/____/____

Financial Policy Agreement

Please read and initial the following in acknowledgement that you read and understand as written:

_____ **Patients WITHOUT insurance benefits need to know...**
The fee for treatment provided must be paid in full on the day of service.

_____ **Patients WITH insurance benefits need to know...**
We will gladly submit claims to your insurance company on your behalf. However, your estimated patient co-pay and deductible for treatment provided must be paid in full on the day of service. Although we will do everything we can to get your claim paid, we must emphasize that our relationship is with you, the patient, not the insurance company. Your insurance is a contract between you, your employer, and/or your insurance company. Our office is not party to that contract, therefore we may, at times, ask for your help in contacting your insurance company to expedite claims when our correspondence doesn't seem to initiate payment. When insurance denies claims or does not pay, the full remainder of your balance will be your responsibility.

_____ **Past due balances are subject to a finance charge.**
Unpaid balances older than 60 days will incur a 1.5 % service charge on every statement from that point forward.

_____ **We accept Cash, Debit Cards, Visa, MasterCard, Discover, AMEX, and personal checks for the amount due.**
We also offer third party financing through Care Credit, Inc. and will gladly help you with the application process. Please ask if you are in need of this service.

_____ **When rescheduling appointments, we kindly ask for 2 business days notice.**
We are blessed with wonderful patients and fully understand that life can be unpredictable. Many times things come up unexpectedly. However, please understand that your appointment time is specifically reserved for you and we do not double book. Please be considerate of this commitment. If unforeseen circumstance does arise and cause the need for rescheduling, you must notify our office within 2 business days in order to reschedule your appointment.

_____ **We will charge a cancellation fee under the following circumstances:**
On the first cancellation we will remind you of our policy and will graciously dismiss your first cancellation fee. If there is a second occurrence, you will be charged a $50 non-refundable cancellation fee that may be used as a deposit in order to reschedule the missed appointment. On the third occurrence of a cancellation or no-show appointment, a second $50 charge will be assessed to your account and the possibility of rescheduling will be questioned.

I hereby authorize my insurance benefits to be paid directly to TL Watson DMD PLLC. I am financially responsible for any balance due. I authorize TL Watson DMD PLLC to release any information required for processing of a claim. I authorize the use of this signature on all insurance submissions whether manual or electronic. Also, I have read and understand TL Watson DMD PLLC's, d.b.a. Midtown Smiles, financial and cancellation policies and do understand fees may be associated with missed appointments.

Patient or Guardian Signature _____ Date _____

MIDTOWN
SMILES

NOTICE OF PRIVACY PRACTICE & ACKNOWLEDGEMENT

I have had full opportunity to read and consider the contents of the HIPAA Notice of Privacy Practices. I understand that I am giving my permission to the clinic for disclosure of my protected health information pertaining to my medical and dental treatment. The purpose of this information is to provide me, the patient, with the best care possible pertaining to my dental treatments, referrals, prescriptions, payment activities, and healthcare operations. Personal information will not be sold to outside companies. I also understand that I have a right to revoke this permission at any time.

By supplying my home phone number, mobile phone number, email address, or any other personal contact information, I authorize Midtown Smiles to employ a third-party automated outreach and messaging system to use my personal information, the name of my care provider, the time and place of my scheduled appointments, and other limited information, for the purpose of notifying me of a pending appointment, missed appointment, overdue wellness visit, or any other reasonable healthcare related communication. I also authorize my healthcare provider to disclose to third parties, who may intercept these messages, limited protected health information regarding healthcare events, unpaid balances, missed appointments and leave a reminder message on my voicemail or answering system if I am unavailable at the number provided by me.

I understand that this information may also be used to contact me for appointment reminders for dental care at the clinic. I give my permission for the clinic to leave messages with persons or voicemail machines at the phone numbers I have provided.

Patient information may be released to the following persons listed below:

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

I have read and understand TL Watson DMD PLLC's, d.b.a. Midtown Smiles, Notice of Privacy Practices as described above and do acknowledge an understand of how my information will or will not be used and/or disclosed to third party participants.

Patient or Guardian Signature _____ Date _____

OFFICE USE ONLY

_____ Patient refused or denied to sign

_____ Emergency situation prevented us from obtaining acknowledgment

_____ Initials of Midtown Smiles Team Member