New Patient Registration

This form can be filled out on a computer, printed, then hand signed.

New Patient Information

Legal First Name | Legal Middle Name / Initial | Legal Last Name | Nickname. If Applicable

Address | City | State | Zip Code

☐ Male ☐ Female

Date Of Birth (ex: 12/12/2012) | Age | Gender (Select One) | Social Security (ex: 123-12-1234) | Driver's License # | State

Mobile Phone (ex: (281) 555-1212) | Home Phone (ex: (281) 555-1212) | E-Mail Address (ex: your@emailaddress.com)

Occupation | Employer | Work Phone (ex: (281) 555-1212)

Employer Address | Employer City | State | Employer Zip Code

Emergency Contact Person (Full Name) | Relationship | Emergency Phone (ex: (281) 555-1212)

Insurance Carrier | Policy Number | Group Number | Ins. Phone (ex: (281) 555-1212)

How did you hear about us? Select One -->
☐ Website ☐ Mailer ☐ Facebook
☐ Referral ☐ Google ☐ Magazine

Whom may we thank for the referral?

Responsible Party Information - ONLY COMPLETE this section if someone other than the patient is responsible to the patient and for all financial responsibilities.

Legal First Name | Legal Middle Name / Initial | Legal Last Name | Nickname. If Applicable

Address | City | State | Zip Code

☐ Male ☐ Female

Date Of Birth (ex: 12/12/2012) | Age | Gender (Select One) | Social Security (ex: 123-12-1234) | Driver's License # | State

Mobile Phone (ex: (281) 555-1212) | Home Phone (ex: (281) 555-1212) | E-Mail Address (ex: your@emailaddress.com)

Occupation | Employer | Work Phone (ex: (281) 555-1212)

Employer Address | Employer City | State | Employer Zip Code

I acknowledge that all of the information above is complete and accurate to the best of my knowledge.

Patient's or Guardian's Signature (please hand sign in pen) | Today's Date

Spring COMPLETE CARE DENTISTRY

Medical History

This form can be filled out on a computer, printed, then hand signed.

First Name | Middle Name / Initial | Last Name | Social Security (ex: 123-12-1234)

Emergency Contact Person (Full Name) | Relationship | Emergency Phone (ex: (281) 555-1212)

List all the medications/drugs you are now taking.

Are you allergic to any of these? Select all that apply. -->

- ☐ Local Anesthetics
- ☐ Codeine or Other Narcotics
- ☐ Erythromycin
- ☐ Aspirin
- ☐ Metals
- ☐ Penicillin
- ☐ Sulfa Drugs
- ☐ Latex Rubber

List any medications/drugs that cause your allergy.

Check any medical conditions you may have below.

- ☐ None
- ☐ AIDS or HIV
- ☐ Alcohol or Drug Abuse
- ☐ Anemia or Leukemia
- ☐ Anorexia or Bulimia
- ☐ Arthritis
- ☐ Asthma or Hay Fever
- ☐ Blood Clotting Problems
- ☐ Blood Transfusion
- ☐ Bronchitis
- ☐ Cancer, Tumor or Growth
- ☐ Cardiac Pacemaker
- ☐ Chest Pain Upon Exertion
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fainting Spells or Seizures
- ☐ Fever Blisters or Herpes
- ☐ Frequent Headaches
- ☐ Frequently Dry Mouth
- ☐ Gall Bladder Trouble
- ☐ Hearth Attack or Stroke
- ☐ Heart Disease or Angina
- ☐ Heart Murmur
- ☐ Hepatitis or Jaundice
- ☐ High Blood Pressure
- ☐ Hives or Skin Rash
- ☐ Joint Replacement
- ☐ Kidney or Bladder Trouble
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Mental Health Problems
- ☐ Mitral Valve Prolapse
- ☐ Persistent Diarrhea
- ☐ Rheumatic Fever
- ☐ Rheumatic Heart Disease
- ☐ Sexually Transmitted Disease
- ☐ Sinus Trouble
- ☐ Sjögren's Syndrome
- ☐ Stomach Ulcer
- ☐ Thyroid Problems
- ☐ Tuberculosis

List any medical conditions or concerns not mentioned above.

Are you pregnant or do you have reason to believe you may be? ☐ Yes ☐ No ☐ Maybe

Do you use tobacco products? ☐ Yes ☐ No If yes, how much and how often?

Do you ever experience an unusual reaction to dental injections? ☐ Yes ☐ No

List the reason for today's visit below.

Name of Former Dentist | City and State | Date of Last Exam or Cleaning

By Signing below, I certify that all of the above information is true to the best of my knowledge.

Patient's or Guardian's Name (printed) | Patient's or Guardian's Signature (please hand sign in pen)

Financial and Scheduling Policy

This form can be filled out on a computer, printed, then hand signed.

Our Commitment: We are dedicated to providing you with the best possible dental care and we are available anytime, should you have any questions, to discuss your obligations for our services. Below is a summary of what we would expect a mutual understanding to exist regarding insurance coverage, your financial responsibilities, and our scheduling policy.

Insurance Coverage: We will do everything possible to help you obtain maximum benefits.

Be advised, however that every insurance contract is between a patient and their insurance carrier. This office is never a party to that insurance contract and will not become engaged in disputes between the patient and the carrier.

The staff at Spring Complete Care Dentistry will call and verify your insurance and file claims as a courtesy. Verified insurance is not a guarantee of payment and every patient is ultimately responsible for any payment not made by the insurance company. Deductible and copays are expected on the day that services are provided. Every patient is responsible for any fees incurred over the maximum annual allowance of the insurance carrier.

By signing below, you are authorizing our office to obtain all information necessary for your insurance claims, and that you release payment from the insurance carrier to Spring Complete Care Dentistry, PLLC.

Patient Financial Responsibility: Patient is responsible for the timely payment of any outstanding balance on his/her account. Any balances outstanding past 90 days may be subjected to late fees and conditions.

A $35 fee will be charged for any returned checks.

Insurance assignments are accepted for a period not to exceed 45 days. If insurance does not pay within 45 days of filing, the financial responsibility becomes that of the patient and the patient is expected to pay the balance in full. If patient accounts are sent to a Collections Agency, all fees and financial obligations for the latter will become that of the patient as well and will be added onto the balances owed.

Scheduling Appointments: For procedures requiring a longer appointment period (crowns, bridges, etc.), a deposit of $100, or the patients copay (if insurance is present), whichever is less, may be required to guarantee the appointment slot. If an appointment needs to be canceled or rescheduled, our office will need to know at least 24 hours before the scheduled appointment. Patients who repeatedly cancel appointments on short-notice or no-show appointments may be declined service at the discretion our office.

Minors (under the age of 18) must be accompanied by an adult.

I,_____ , acknowledge that all information I have provided here in this Financial and Scheduling Policy; is truthful and accurate to the best of my knowledge.

_____ _____

Patient's or Guardian's Signature (please hand sign in pen) Today's Date

Spring
COMPLETE CARE
DENTISTRY

Smile Evaluation

This form can be filled out on a computer, printed, then hand signed.

_____ _____

Patient's Full Name (please print legibly) Today's Date

Are you interested in braces? ☐ Yes ☐ No

Are you interested in tooth bleaching? ☐ Yes ☐ No

Briefly list any cosmetic concerns you have with your smile. Dr. Tan will carefully evaluate your concerns during your consultation and suggest possible treatment specifically for you.

Are you considering or curious about a particular cosmetic procedure, such as veneers, crowns, whitening, etc.?

I, _____, acknowledge that the information I have provided here in this Smile Evaluation is truthful and accurate to the best of my knowledge.

_____ _____

Patient's or Guardian's Signature (please hand sign in pen) Today's Date

Health Insurance Portability and Accountability Act

This form can be filled out on a computer, printed, then hand signed.

Health Insurance Portability and Accountability Act: Our office fully understands the need for patient privacy and we will take every precaution and action to enforce this. The office will be very happy to provide a copy of the NOTICE OF PRIVACY PRACTICES (HIPAA) to you at any time upon request. This is an acknowledgment that you understand this right and our commitment to you.

_____ _____

Patient's or Guardian's Signature (please hand sign in pen) Today's Date