Adult New Patient Form

Date: _____

The information given will be used in strict confidence to prepare your dental chart.

Birth date: _____

Name: _____ Age: _____

Family Physician: _____ Date of last visit: _____

Whom may we thank for referring you to us: _____

Purpose of today's visit (any specific concerns): _____

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

Heart problems, murmur or surgery	Yes	No	Kidney problems	Yes	No
Rheumatic fever	Yes	No	Hepatitis or jaundice	Yes	No
High or low blood pressure	Yes	No	Fainting spells	Yes	No
Congenital heart lesions	Yes	No	Stroke	Yes	No
Blood disorders (anemia, etc)	Yes	No	Stomach problems or ulcers	Yes	No
Bleeding problems or hemophilia	Yes	No	Thyroid condition	Yes	No
Seizures or epilepsy	Yes	No	Nervousness	Yes	No
Asthma, tuberculosis or lung problems	Yes	No	Tumors, growths or cancer	Yes	No
Arthritis	Yes	No	Psychiatric treatment	Yes	No
Venereal Disease	Yes	No	Liver Problems	Yes	No
Joint Replacement Surgery	Yes	No	Diabetes	Yes	No
Compromised Immune System	Yes	No	Other (explain)	Yes	No

	Circle One	
Are you in good health	Yes	No
Has there been any change in your general health within the past year	Yes	No
Are you under the care of a physician	Yes	No
If so, what is the condition being treated _____		
Have you had any serious illness or operation	Yes	No
If so, what was the illness or operation _____		

Have you had abnormal bleeding associated with a previous extraction or surgery	Yes	No
Are you taking any drugs or medications	Yes	No
If so, what _____		
Are you allergic or have you reacted adversely to any drug or medication	Yes	No
If so, what _____		
Have you had serious trouble associated with any previous dental treatment	Yes	No
Do you have any disease, condition or problem not listed above that I should know about	Yes	No
If so, explain _____		

Women

Are you pregnant	Yes	No

Previous Dentist: _____ Last Visit: _____

Spouse's Name: _____

Single _____ Married _____ Divorced _____ Widowed _____

Your home address: Street _____ City _____

State _____ Zip _____

Home Phone: _____ Cell Phone: _____ Email address: _____

Occupation: _____

Name and address of business: _____ Phone #_____

Spouse's Occupation: _____

Name and address of business: _____ Phone #_____

Person responsible for account: _____

CONSENT

I certify the truth of all information given. I authorize the release of pertinent information to those persons requiring it for treatment, for the purpose of payment of the account, or credit references. I hereby grant permission to Dr. Rector and/or legally qualified associates to perform those diagnostic and treatment procedures, including local anesthesia, operative procedures, and dental radiographs as may be deemed necessary or advisable for the proper diagnosis and treatment.

Patient's Signature: _____ Date: _____

Witness: _____ Date: _____

DENTAL INSURANCE INFORMATION

If your account is to be handled by any other method than direct payment to the office, please complete the following section for our records. Your help with this information aids in expediting your dental claim. Check one of the following:

Insurance: _____ Medicaid: _____

If Insurance:

Insurer's Name: _____
Address: _____
Social Security or Identification # _____
Insurance Company: _____
Place of employment: _____

The Rector Dental Group

Adult HIPPA

Section A: The Patient

Name: _____

Address: _____

Phone: (____) _____-_____ Email: _____

Section B: Acknowledgement of Receipt of Privacy Practice Notice

I, _____, acknowledge that I have received a Notice of Privacy Practices from the above-named practice.

Signature:_____ Date: _____/_____/_____

If a personal representative signs this authorization on behalf of the individual, complete the following:

Personal Representative's Name: _____

Relationship to Individual: _____

Section C: Changes to our office policy:

There are to be under no circumstances, cell phone usage in operatories.

We may disclose patient records to another provider by submitting them electronically.

Family, friends, and other involved in your car or payment for care: We may disclose your child's medical information to a family member, friend or any other person involved in your child's care or payment of your child's health care. We will disclose only the medical information that is relevant to the person's involvement.

Signature:

I attest that the above information is correct.

Signature:_____ Date: _____/_____/_____

Print Name: _____ Relationship: _____

AUTHORIZATION
TO RELEASE DENTAL NEEDS

The Rector Dental Group

Our mission is to be dedicated to protecting the dental health of our patients. We are proud to provide dental care to children and adults of the community. Our office combines the latest dental knowledge and technology together with care and compassion. We want every patient to have a positive dental experience. Our expert staff is great in creating this experience. Your commitment along with our excellent care, will allow for a lifetime of healthy teeth and gums.

Patients Name Date of Birth

It is the policy of my office to not release dental patient information about you, unless it is for patient care and treatment or payment. We try to the best of our ability to keep the discussion of patient information to a minimum. If you wish for our dentist and/or office staff to leave messages for you on your home telephone, message number, answering machine, work telephone, voice mail, cell phone, or pager, or to any other person, then you must complete the following:

I authorize The Rector Dental Group or staff to release dental patient information about me by the following methods and agree it is my responsibility for notifying my dentist or office staff whenever I want this to change:

We can call your home or cell number if applicable and leave a message if no answer Yes ___ No___
We can call you at work Yes ___ No___
We can communicate with other professional offices and/or insurance companies concerning patient information Yes ___ No___

You may disclose information to my family members and or non-family members. Please list name and relationship.

NAME RELATIONSHIP

Patient Signature Date

Witness Date

SIGNATURE ON FILE

Patient's Name: _____
Last First Middle Initial

I hereby authorize payment of the dental benefits otherwise payable directly to The Rector Dental Group.

_____
Signature (Insured Person) Date

The Rector Dental Group is authorized to provide pertinent information to those persons requiring it for the use of evaluating and administrating claims for benefits.

I authorize the use of this form on all of my insurance submissions.

I permit a copy of this authorization to be used in place of the original.

I understand that I am responsible for my bill.

_____
Parent, Legal Guardian or Authorized Person's Signature Date

APPOINTMENTS & FINANCIAL POLICY

The Rector Dental Group

APPOINTMENTS

When you make an appointment with us please arrive on time since we have reserved this time just for you. Please make every effort not to change your scheduled appointment. If you must change an appointment please provide us at least a 24 hour notice so that we may use our time to accommodate other patients. Broken and missed appointments create scheduling problems for other patients and our practice. We value your time, please value ours. We will call to confirm your appointment one to two days in advance. It is very important to our office for you to confirm your appointment with our staff or answering service if we are unable to contact you.

FINANCIAL POLICY

For your convenience we accept cash, check, Visa, MasterCard, Discover, and American Express. We also bill all dental insurance plans. In most cases dental insurance is a benefit with limitations and should not to be expected to take care of all costs. Your dental benefits and how they relate to your specific needs will be explained to you during treatment discussion. Unless another financial option is pre-arranged, payment is due in full the day of treatment. If you have dental insurance the estimated patient portion will be the amount due.

I have read and fully understand the appointment and financial policies.

SIGNATURE DATE