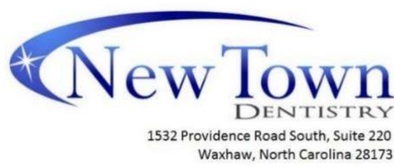

New Patient Registration

Patient Information

Name: ____

Preferred Name: ______________________ Date of Birth: ______/______/________ Age: ________

Social Security Number: _________- ________- _________ Driver's License Number: ______________________

Marital Status: (Circle One) Single/Married/Divorced/Separated/Widow Gender: ___________________________

Address: ____

City: ___________________________________ State: ____________ Zip: ___________________________

Phone Number: (h): ____________________ (w) ____________________ (c) ____________________

Email Address: ____

Referral Information

How did you hear about us? (Circle all that apply)

Insurance Plan Web-Search Location Family Member: ______________________

Friend: ______________________________ Physician/Specialist: ______________________________

Other: ______________________________ May we thank the person who referred you? Yes No

Responsible Party

(Person responsible for billing, **if different** from the patient)

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

Best Contact Number: ____ Are they an existing patient here? Yes No

Insurance Information

Policy Holder's Name: _______________________________________ Date of Birth: _____/_____/_________

Relationship to Patient: (Circle One) Self/Spouse/Child/Other: ______________________________________

Employer: ____ Employer Phone #: ______________________

Member ID # OR Social Security #: _______________________ Group ID#: ___________________________

Insurance Company: ____________________________________ Phone #: _____________________________

Secondary Insurance? Yes No If yes, please provide that information as well on the reverse side.

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to New Town Dentistry, Dr. Douglas A. Wolfe, DDS, PLLC. I understand that I am financially responsible for any balance. I also authorize New Town Dentistry or my insurance company to release any information necessary to process my claims.

Patient/Guardian Signature: ____ Date: ______________________

****See Reverse Side to Complete****

ACKNOWLEDGMENT OF RECEIPT OF

HIPAA NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received and reviewed a copy of New Town Dentistry, Dr. Douglas Wolfe, HIPAA Notice of Privacy Practices.

Patient Name (Please Print): ____

Patient Signature: ______________________________________ Date: ____________________

OR

Signature of Personal Representative: ____

Authority of Personal Representative to Sign for Patient (check one):

□ Parent □ Guardian □ Power of Attorney □ Other: __________________________________

Please Note: It is your right to refuse to sign this Acknowledgment.

Dental Office Use Only

I tried to obtain written Acknowledgment by the individual noted above of receipt of our Notice of Privacy Practices, but it could not be obtained because:

_____ An emergency prevented us from obtaining acknowledgment.

_____ A communication barrier prevented us from obtaining acknowledgment.

_____ The individual was unwilling to sign.

_____ Other:____

Staff Member Signature: _______________________________ Date: _________________

New Town Dentistry

Medical History

Patient Name: ____ DOB: _______________________________

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.			
			If Yes, Please Specify.
Are you under a physician's care now?	□ Yes	□ No	
Have you ever been hospitalized or had a major operation?	□ Yes	□ No	
Have you ever had a serious head or neck injury?	□ Yes	□ No	
Are you taking any medications, pills, or drugs?	□ Yes	□ No	
Do you take, or have you taken, Phen-Fen or Redux?	□ Yes	□ No	
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	□ Yes	□ No	
Are you on a special diet?	□ Yes	□ No	
Do you use tobacco?	□ Yes	□ No	
Do you use controlled substances?	□ Yes	□ No	

Women: Are you…

□ Pregnant/Trying to get pregnant? □ Nursing? □ Taking oral contraceptives?

Are you allergic to any of the following?

□ Aspirin □ Penicillin □ Codeine □ Acrylic
□ Metal □ Latex □ Sulfa Drugs □ Local Anesthetics

□ Other? If yes:____

****See Reverse Side to Complete****

Do you have, or have you had, any of the following?											
AIDS/HIV Positive	□ Yes	□ No	Cortisone Medicine	□ Yes	□ No	Hemophilia	□ Yes	□ No	Radiation Treatments	□ Yes	□ No
Alzheimer's Disease	□ Yes	□ No	Diabetes	□ Yes	□ No	Hepatitis A	□ Yes	□ No	Recent Weight Loss	□ Yes	□ No
Anaphylaxis	□ Yes	□ No	Drug Addiction	□ Yes	□ No	Hepatitis B or C	□ Yes	□ No	Renal Dialysis	□ Yes	□ No
Anemia	□ Yes	□ No	Easily Winded	□ Yes	□ No	Herpes	□ Yes	□ No	Rheumatic Fever	□ Yes	□ No
Angina	□ Yes	□ No	Emphysema	□ Yes	□ No	High Blood Pressure	□ Yes	□ No	Rheumatism	□ Yes	□ No
Arthritis/Gout	□ Yes	□ No	Epilepsy or Seizures	□ Yes	□ No	High Cholesterol	□ Yes	□ No	Scarlet Fever	□ Yes	□ No
Artificial Heart Valve	□ Yes	□ No	Excessive Bleeding	□ Yes	□ No	Hives or Rash	□ Yes	□ No	Shingles	□ Yes	□ No
Artificial Joint	□ Yes	□ No	Excessive Thirst	□ Yes	□ No	Hypoglycemia	□ Yes	□ No	Sickle Cell Disease	□ Yes	□ No
Asthma	□ Yes	□ No	Fainting Spells/Dizziness	□ Yes	□ No	Irregular Heartbeat	□ Yes	□ No	Sinus Trouble	□ Yes	□ No
Blood Disease	□ Yes	□ No	Frequent Cough	□ Yes	□ No	Kidney Problems	□ Yes	□ No	Spina Bifida	□ Yes	□ No
Blood Transfusion	□ Yes	□ No	Frequent Diarrhea	□ Yes	□ No	Leukemia	□ Yes	□ No	Stomach/Intestinal Disease	□ Yes	□ No
Breathing Problems	□ Yes	□ No	Frequent Headaches	□ Yes	□ No	Liver Disease	□ Yes	□ No	Stroke	□ Yes	□ No
Bruise Easily	□ Yes	□ No	Genital Herpes	□ Yes	□ No	Low Blood Pressure	□ Yes	□ No	Swelling of Limbs	□ Yes	□ No
Cancer	□ Yes	□ No	Glaucoma	□ Yes	□ No	Lung Disease	□ Yes	□ No	Thyroid Disease	□ Yes	□ No
Chemotherapy	□ Yes	□ No	Hay Fever	□ Yes	□ No	Mitral Valve Prolapse	□ Yes	□ No	Tonsillitis	□ Yes	□ No
Chest Pains	□ Yes	□ No	Heart Attack/Failure	□ Yes	□ No	Osteoporosis	□ Yes	□ No	Tuberculosis	□ Yes	□ No
Cold Sores/Fever Blisters	□ Yes	□ No	Heart Murmur	□ Yes	□ No	Pain in Jaw Joints	□ Yes	□ No	Tumors or Growths	□ Yes	□ No
Congenital Heart Disorder	□ Yes	□ No	Heart Pacemaker	□ Yes	□ No	Parathyroid Disease	□ Yes	□ No	Ulcers	□ Yes	□ No
Convulsions	□ Yes	□ No	Heart Trouble/Disease	□ Yes	□ No	Psychiatric Care	□ Yes	□ No	Venereal Disease	□ Yes	□ No
									Yellow Jaundice	□ Yes	□ No

Have you ever had any serious illness not listed above? If yes, :____

Comments:

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:

X	Date:

New Town Dentistry
Authorization for Release of Information – Compound Release

Name of Patient ____ Date of Birth ______________

New Town Dentistry is authorized to release protected health information about the above named patient in the following manner and to identified persons.

Check each person/entity that you approve to receive information.	**Description of information to be released.** Check each that can be given to person/entity on the left in the same section.
☐ Voice Mail	☐ Appointment Reminders
☐ (EMERGENCY CONTACT) , Other person (s) (provide name and phone number)(i.e. Spouse, Parent, Aunt, Uncle, Grandparent etc.) ☐ ______________________________________ ☐ ______________________________________ ☐ ______________________________________	☐ Financial ☐ Treatment/Treatment Plans
☐ Email communication-Provide email address* ___________________________________ *For email communication to occur, please accept the disclosure below:	☐ Financial ☐ Treatment/Treatment Plans ☐ Appointment reminders ☐ Breach notification
☐ Text communication – Provide number * ___________________________________ *For text communication to occur, accept the disclosure below:	☐ Appointment reminder ☐ Special Events / Newsletters
☐ For **email and/or text communication** I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to receive email and/or text communication as selected.	
☐ Photo taken by staff (Example: pre/post procedure) ☐ Name and Photo	☐ May be posted in office ☐ May be posted on website ☐ Post on Facebook

Patient Rights:

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

This authorization will remain in effect until revoked by the patient.

____Date ___________________
Signature of Patient or Personal Representative

****See Reverse Side to Complete****

New Town Dentistry
1532 Providence Road South, Suite 220
Waxhaw, North Carolina 28173

APPOINTMENT, FINANCIAL, AND INSURANCE INFORMATION

APPOINTMENTS

Our office is growing and we are very excited about that! We will always respect your time and our team will make every effort to schedule appointments that accommodate the needs of all of our patients. When you make an appointment we reserve the time, Dr. Wolfe, the team and the treatment room individually for you. Because our office is growing we do run a tight schedule and ask you to be on time for the appointment. To be fair if you arrive later than 10 minutes in to your appointment time we may have to reschedule or we will attempt to do as much as we can. For your convenience, we will call with an appointment reminder at least 2 business days prior to your scheduled appointment. When a patient appointment is broken or an appointment is missed, it creates scheduling challenges for other patients as well as for our dental office. Our dental office will charge a fee for cancellations and appointment failures without a notice of **48 business hours**. We understand that emergencies and personal situations do arise. New Town Dentistry may collect a deposit on large cases prior to the appointment to reserve the specific time. ****For Children, UNDER THE AGE OF 18, a parent or guardian is required to be present at all appointments unless prior authorization has been made.****

FINANCIAL

Payment is due at the time that services are rendered. For your convenience we have provided several payment options to help you with your financial needs. Your smile is important to us and we want you to receive the treatment you need. New Town Dentistry makes it easy and convenient to fit dental care into your budget. Therefore we accept many forms of payment including cash, check, credit cards, flex spending, Lending Club and CareCredit. To keep your account current, payment is due at the time that dental services are rendered unless arrangements have been made in advance. Unpaid balances should be paid within 45 days of office visit. Should your account remain past due after 90 days, we reserve the right to refer your overdue account to a third party for collections. ****For Children, UNDER THE AGE OF 18, a parent or guardian is the primary "responsible party" and is responsible for any copayment at time of service even if a parent or guardian cannot be present at the appointment time.****

Financial Plans and Discounts

- **5% prepayment discount:** On full case plans, we offer a pre-payment by cash, check, or credit card 48 hours prior to treatment
- **Full fee paid at time of treatment:** (payment by cash, check, or credit card)
- **1/2 and 1/2:** On Major treatment that requires more than one appointment to complete.
- **CareCredit™ and Lending Club financing**

INSURANCE

For your convenience we accept various forms of dental insurance and we will work with you to maximize your benefits. Our financial coordinator will help you to better understand your insurance plan. All treatment plans are only an estimate and not a guarantee of coverage and will be VOIDED after 90 days. We try to get the closet estimate that we can from your insurance company but it still is important for you as our patient to familiarize yourself with your insurance benefits.

As a courtesy, our office will gladly:

- Submit your insurance claim on the day of your visit.
- Verify insurance eligibility of your dental plan and what they estimate to pay prior to your appointment.
- Attach all supporting documentation to your claim, such as narratives and appropriate radiographs.
- Send preauthorization's on large treatment plans to determine what the insurance will cover.
- Follow the American Dental Association guidelines for coding and filing insurance claims.

As the Insurance policy holder, it is your responsibility to:

- Keep our office informed of any changes to your insurance coverage or employment.
- Understand that although we participate with your insurance plan, you own the policy and we have no leverage to obtain payments or benefits from your insurance carrier. You are responsible for all fees associated with your treatment regardless of your insurance coverage.
- Any charges not covered under an insurance plan will be patients' responsibility.
- Familiarize yourself with your insurance coverage, co-payments, deductible, and annual maximums.

I, ________________________________, certify by my signature that I have read the above Appointment, Financial, and Insurance Information and will comply.

Signature: ____ Date: ______/______/______