New Patient Registration

Name _____ What do you prefer we call you? _____ Date of birth _____

Address _____ City _____ State _____ Zip_____

Phone _____Email _____ Spouse/Parent Name _____

Please circle all that apply: Male, Female, Other, Single, Married, Separated, Divorced, Widowed, Child

Emergency contact _____Relationship _____ Phone_____

Dental Insurance - Primary

Employee's name_____Date of birth _____

Employer _____How many years?____

Name of insurance company _____

Address _____

City _____State _____ Zip _____

Phone _____ Group #_____

Employee SS#_____Member ID#_____

Dental Insurance - Secondary

Employee's name_____Date of birth _____

Employer _____How many years?____

Name of insurance company _____

Address _____

City _____State _____ Zip _____

Phone _____ Group # _____

Employee SS#_____Member ID#_____

AUTHORIZATION AND RELEASE: I authorize the dentist to perform diagnostic procedures and treatments as maybe necessary for proper dental care. I authorize release of any information concerning My or my child's healthcare, advice and treatment provided for the purpose of evaluation and administering claims for health insurance benefits. I authorize release of any information concerning My or my child's healthcare, advice and treatment to another dentist or physician. I hereby authorize payment of insurance benefits directly to the dentist. I understand that my dental insurance carrier or payer of my dental benefits, may pay less than the actual charges for services. I understand that I am financially responsible for payments in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services, not paid, in whole or in part, by my dental care payer.

FEES AND PAYMENTS. we are here to provide the best dental experience and the best dental care for you and your family. We're happy to bill your insurance for Services rendered in our office. All copayments are due at the time of service. For your convenience we accept all major credit cards checks and cash for payment. If you're dental insurance is not affiliated with Delta Dental we offer a 5% discount for payment for the entire cost of treatment, including the estimated insurance coverage, at the time of service by check. delta dental members already received a significant discount because our office is contracted with them. you will be responsible for any balance remaining after the insurance pays. By signing this. I am fully aware of the financial policy for Rosenwald and Associates. I give them permission to bill my insurance company. I understand that my insurance may not pay the entire fee and I accept responsibility for any balances not paid. I agree to remit payment in for any balance in a timely manner.

FINANCIAL DISCLOSURE. The truth in lending law enacted in 1969 serves to inform borrowers and installment purchasers of the true annual interest charged. Balances 90 days past due are subject to a finance charge of 1.5% per month or 18% per year. I acknowledge that if default payment results in this account and being turned over for collection, I will be responsible for the full fee plus collection fees, legal fees, in any other accumulated fees.

NO SHOW / LATE CANCELLATION POLICY. We understand that you may need to cancel an appointment occasionally. In those circumstances, please contact us no later in 24 hours before you scheduled appointment time so that we may offer that time to another patient. You may do so by calling the office at 425 454-4040. If you do not show up for your appointment or cancel last minute, we will consider that a no-show and you may be subject to $126 no-show fee. We know that unexpected situations sometimes arise. In case of emergencies or extenuating circumstances, we may waive the no-show fee. Waivers are determined on a case-b-y-case basis at the practice management's sole discretion.

Patient's or Guardian's Signature _____ Date _____

Rosenwald and Associates. Privacy Practices:

I Acknowledge that I received or have been offered a copy of the statement of privacy practices for the offices of Rosenwald and Associates. The statement of privacy practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office healthcare operations. The statement of privacy practices also describes my rights and responsibilities and the duties of this office with respect to my protected health information. The statement o f privacy practice is also posted in the facility. Rosenwald and Associates reserve the right to change the privacy practice currently described in the Statement of Privacy Practice. If privacy practices change, I will be offered a copy of the revised statement of privacy practice at the time of my first visit after the revisions become effective. I may also obtain a revised statement of privacy practice by requesting one that will be mailed or otherwise transmitted to me.

Protected information cannot be shared with anyone unless otherwise allowed by HIPPA. in addition to the allowable disclosures described in the statement of privacy practices I hereby specifically authorize disclosure of my protected healthcare information to the persons identified below.

YES NO Spouse

YES NO Immediate family (i.e. spouse, children, children's spouse)

YES NO Extended family (i.e. parents, grandchildren)

YES NO Specific other. Name _____

Patient's name (please print)_____

Signature (if 18+ years of age) _____Date_____

Patient's personal representative (please print)_____

Personal representative's phone number _____

Signature_____ Date _____

HEALTH HISTORY FOR: _____. Date: _____

YES NO **Are you currently under a physician's care?** If so, why _____

Physician's name: _____ Phone: _____ Date of last physical_____

YES NO **Are you taking any medications or health related substances?** If so, what?

Medication_____For_____ Medication_____For_____

Medication_____For_____ Medication_____For_____

Medication_____For_____ Medication_____For_____

Medication_____For_____ Medication_____For_____

Medication_____For_____ Medication_____For_____

Medication_____For_____ Medication_____For_____

YES NO **Are you allergic to any medications, latex, or other substances?** If so, what? _____

Do you have or have you ever had:

YES NO Asthma, other respiratory difficulties

YES NO Rheumatic fever

YES NO Heart Murmurs

YES NO High blood pressure

YES NO Pacemaker

YES NO Artificial heart valves

YES NO Blood disorders, anemia, leukemia

YES NO Radiation to head/neck area

YES NO Arthritis or rheumatism

YES NO Bone joint replacement surgery

YES NO Other implants or prosthesis

YES NO Stomach problems, acid reflux, ulcers

YES NO Thyroid, hypo or hyper

YES NO Excessive bleeding

YES NO Do you take blood thinners

YES NO Cold sores or canker sores

YES NO Epilepsy or seizure disorders

YES NO Kidney or liver problems

YES NO Hepatitis

YES NO Diabetes

YES NO Positive HIV test or AIDS

YES NO Tuberculosis

YES NO Psychiatric treatment

YES NO Drug or alcohol addiction

YES NO Cancer: Type?_____ Are you currently under treatment? _____

YES NO Do you smoke, vape, or use any forms of tobacco? If so, what? _____How often?_____

YES NO Have you taken oral or IV drugs for bone density (Bisphosphonates) such as but not limited to Actonel, Boniva, Fosamax, Alendronate, Risedronate, and Zometa

YES NO Have you ever been advised to take a premedication prior to dental appointment? If so, why and what?

WOMEN:

YES NO Are you pregnant?

YES NO Are you aware that some antibiotics may interfere with the effectiveness of some birth control medication?

Is there anything else we should know about your health? If so, please explain: _____

_____

Signature: _____ **Date:** _____

Dear new patient,

Welcome to our practice! We are delighted to have you as part of our dental family. Dr Jim, Dr Susan, and our entire team are committed to providing exceptional care tailored to your individual needs. Our goal is to listen, understand your concerns, and work with you to create a plan that helps you achieve and maintain a healthy, confident smile. We believe that the best dental care begins with open communication and trust. Whether your goals are maintaining oral health, improving your smile or addressing specific concerns, we are here to support you every step of the way. We look forward to partnering with you on your journey to optimal oral health.

Please help us understand more about you, your concerns, and your dental health.

Select one word that best describes your dental health.

☐ Excellent ☐ Good ☐ Fair ☐ Poor

How happy are you with your smile?

☐ Very happy ☐ Mostly happy ☐ Not happy

Are there changes you would like to consider for your smile? If so, what are those changes?

_____

Can you chew well and comfortably?

☐ Yes ☐ No If no, please explain _____

What are your goals for your teeth and your oral health? _____

Are there any special concerns that you have or anything else you would like us to know about you, your teeth or your oral health?

_____

Have you had your wisdom teeth removed? YES NO

Have you ever had orthodontic (braces/Invisalign) treatment? YES NO

Do you currently wear: A night guard - YES NO. A sleep appliance – YES NO. Retainers - YES NO

What do you use to care for your teeth daily?

☐ Toothbrush ☐ Floss ☐ Waterpik ☐ Other _____

Who referred you to our office and what is your relationship to them?

_____

Is there anything else we should know in order to give you the best and most appropriate care for you? _____

Name: _____ Date: _____