DENTAL SYMMETRY

New Patient Registration Form

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Please complete this form and bring it with you to your first appointment. All information is kept confidential.

PERSONAL INFORMATION

Last Name ______ First Name ______ Date of Birth (MM/DD/YYYY) ______

Gender: ☐ Male ☐ Female ☐ Other Email Address ______ Phone Number ______

Street Address ______ Apt/Suite ______ City ______

State ______ Zip Code ______

EMERGENCY CONTACT

Contact Name ______ **Phone Number** ______ **Relationship** ______

INSURANCE INFORMATION

Do you have dental insurance? ☐ **Yes** ☐ **No** **(If No, skip to Medical History)**

Insurance Company ______ **Policy/Member ID** ______

Group Number ______ **Subscriber Name (if not self)** ______ **Subscriber DOB** ______

Relationship to Subscriber: ☐ **Self** ☐ **Spouse** ☐ **Child** ☐ **Other**

MEDICAL HISTORY

Please list any medical conditions you have been diagnosed with:

Please list all current medications (including vitamins and supplements):

Please list any allergies (medications, latex, etc.):

DENTAL SYMMETRY

New Patient Registration Form (continued)

DENTAL HISTORY

Date of Last Dental Visit ______________________

Previous Dentist Name ______________________

What dental concerns would you like us to address? (Check all that apply)

- ☐ Cleaning/Checkup
- ☐ Tooth Pain
- ☐ Cavities
- ☐ Gum Problems
- ☐ Bad Breath
- ☐ Teeth Whitening
- ☐ Broken/Chipped Tooth
- ☐ Missing Teeth
- ☐ Cosmetic Concerns

Other concerns or additional information:

HOW DID YOU HEAR ABOUT US?

- ☐ **Friend/Family Referral**
- ☐ **Google Search**
- ☐ **Social Media**
- ☐ **Insurance Provider**
- ☐ **Drive/Walk By**
- ☐ **Yelp/Online Reviews**
- ☐ **Other:** ______________________

CONSENT AND ACKNOWLEDGMENT

I certify that the information I have provided is true and correct to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health. I authorize Dental Symmetry to release any information, including the diagnosis and records of treatment, to third-party payors and/or health practitioners as needed.

I consent to examination, treatment, and procedures as deemed necessary by the dental professionals at Dental Symmetry. I understand that I have the right to ask questions about any treatment and to accept or refuse treatment.

I acknowledge that I have received and understand the Notice of Privacy Practices (HIPAA), which describes how my health information may be used and disclosed.

____

Patient Signature (or Parent/Guardian if minor)

____

Date

____

Print Name

FOR OFFICE USE ONLY

Date Received: ______________ Entered By: ______________ Verified: ☐

Notes: ____