PATIENT REGISTRATION

"Changing the World, One Smile at a Time…"

PATIENT INFORMATION:

NAME:_____DOB:_____SEX:_____

ADDRESS:_____

CELL:_____WK:_____HM:_____

WIRELESS CARRIER:_____E-MAIL:_____

IF MINOR, SCHOOL:_____GRADE:_____

REFERRRED BY:_____GEN DENTIST:_____

RESPONSIBLE PARTY INFORMATION:

NAME #1:_____RELATIONSHIP:_____

ADDRESS: _____HOW LONG:_____

C:_____W:_____H:_____

E-MAIL:_____

MARITAL STATUS:_____

EMPLOYER:_____OCCUPATION:_____

HOW LONG HAVE YOU WORKED THERE ? _____

NAME #2:_____RELATIONSHIP:_____

C:_____W:_____H:_____

E-MAIL:_____

EMPLOYER:_____OCCUPATION: _____

HOW LONG HAVE YOU WORKED THERE ? _____

EMERGENCY INFORMATION:

EMERGENCY CONTACT: _____

RELATIONSHIP: _____

C:_____W:_____ H: _____

I understand that where appropriate, credit bureau reports may be obtained. The examination and consultation may be monitored or recorded by video camera for training purposes of employees of Newhart Orthodontics.

SIGNATURE:	**DATE:**

HEALTH HISTORY QUESTIONNAIRE

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING:

Yes / No Rheumatic Fever	Yes / No Kidney problems	Yes / No Diabetes
Yes / No Rheumatic Heart Disease	Yes / No Bacterial Endocarditis	Yes / No Epilepsy/seizure
Yes / No Heart Murmur	Yes / No Heart valve prosthesis	Yes / No Prolonged bleeding
Yes / No Congenital Heart Disease	Yes / No Joint prosthesis	Yes / No Asthma
Yes / No Mitral Valve Prolapse	Yes / No Cardiac pacemaker	Yes / No Arthritis
Yes / No Systemic Lupus	Yes / No Hypertrophic Cardiomyopathy	Yes / No High Blood pressure

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INFECTION CONTROL:

Yes / No Hepatitis, when _____
Yes / No Are you a carrier?
Yes / No Cold sores / fever blisters
Yes / No HIV positive: _____
Yes / No AIDS: _____
Yes / No Other Infections: _____
_____
_____

ALLERGIES:

Yes / No PCN
Yes / No SULFA
Yes / No FEN-PHAN
Yes / No LATEX
Other: _____
_____
_____
_____
_____

Yes / No Are you under the care of a physician? _____
_____
_____
_____
_____
_____
_____
_____
_____

OTHER MEDICAL CONDTIONS:

_____
_____
_____
_____
_____
_____
_____
_____

CURRENT MEDICATION: YES / NO

1. _____ Reason: _____
2. _____ Reason: _____
3. _____ Reason: _____
4. _____ Reason: _____

WOMEN:

Yes / No Are you pregnant?
Trimester 1st / 2nd / 3rd
Due Date: _____
Yes / No Breast Feeding?

DENTAL - Do you have, or have you had, any of the following:

Yes / No Loose teeth?	Yes / No Bleeding, sore gums?	Yes / No Have you ever had gum disease?
Yes / No Sensitive to hot?	Yes / No Unpleasant taste/bad breath?	Yes / No Have you ever had periodontal/gum treatment?
Yes / No Sensitive to cold?	Yes / No Frequent blisters, lips/mouth?	Yes / No Have you ever had surgery in your mouth?
Yes / No Sensitive to sweets?	Yes / No Swelling/lumps in mouth?	When?: _____
Yes / No Sensitive to biting?	Yes / No Biting cheeks/lips?	_____

PREMEDICATION:

Yes / No Antibiotic premedication suggested by M.D.?

Yes / No Antibiotic premedication used previously?

OTHER DENTAL CONCERNS:

_____
_____
_____
_____

UNDERSTAND THAT THE INFORMATION I PROVIDE ON THIS FORM IS ESSENTIAL TO DETERMINE MY DIAGNOSIS AND THE PROVISIONS OF TREATMENT. I UNDERSTAND THAT IF ANY CHANGE OCCURS IN MY HEALTH I AM TO REPORT IT TO THIS OFFICE AS SOON AS POSSIBLE. I HAVE READ AND UNDERSTAND EACH QUESTION, AND HAVE ANSWERED ALL OF THEM TRUTHFULLY AND TO THE BEST OF MY ABILITY. I HAVE DISCUSSED MY HEALTH HISTORY WITH THIS DOCTOR.

_____ DATE	_____ PATIENT SIGNATURE	_____ DATE	_____ DR. SIGNATURE

_____ (DATE)	_____ (DR INITIALS)	_____ (DATE)	_____ (DR INITIALS)	_____ (DATE)	_____ (DR INITIALS)	_____ (DATE)	_____ (DR INITIALS)

INSURANCE COVERAGE

Newhart ORTHODONTICS

"Changing the World, One Smile at a Time…"

Orthodontic
Carrier #1: _____

Insured
Name: _____

Insured
ID# / SS#: _____D.O.B._____

Orthodontic
Carrier #2: _____

Insured
Name: _____

Insured
ID# / SS#: _____D.O.B._____

PATIENT NAME: _____

Newhart
ORTHODONTICS

"Changing the World,
One Smile at a Time..."

Name:	Date:

Payment Plan Options

Option 1 : No down payment. Monthly payments as low as $125/month.
Shorter payment period extending no longer than treatment time.

Option 2 : No down payment. Monthly payments as low as $79/month.
Low interest. Payment period can extend beyond treatment time.

Option 3 : Pay in full before the start of treatment. Easiest and least expensive.
8 % discount cash or check / 5 % discount credit card on patient portion of total orthodontic fee.

		_____ _____ Total Fee _____ Total Fee _____ Ins. Est. _____ Ins. Est. _____ Balance _____ Balance _____ Down Pmt. _____ Down Pmt. _____ Balance _____ Balance _____ # Mos. ( ) _____ # Mos. ( ) _____ _____ Total Fee _____ Ins. Est. _____ Balance _____ Down Pmt. _____ Balance _____ # Mos. ( ) _____ X-Rays:

416 N. Bedford Drive
Suite 311
Beverly Hills, CA 90210
Ph (310) 550-1533
Fax (310) 274-9756

301 Arizona Ave.
Suite 300
Santa Monica, CA 90401
Ph (310) 393-9389
Fax (310) 394-3366

321 N. Larchmont Blvd.
Suite 500
Los Angeles, CA 90004
Ph (323) 463-3173
Fax (323) 463-3379

3516 W. Imperial Hwy.
Suite 100
Inglewood, CA 90303
Ph (310) 330-3686
Fax (310) 330-3688

126 N. Locust
Inglewood, CA 90301
Ph (310) 677-1101
Fax (310) 677-4810

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CRM Administration

1. Exam Results_____

2. If Scheduled to Start enter start appointment information:

   Day:_____

   Date:_____

   Time:_____

   Office:_____

3. If Undecided enter NextCall™ in _____ Days or _____Weeks

4. If Pending Insurance NextCall™ in _____ Days or _____Weeks

5. If Not Ready for Treatment NextCall™- Recall in _____ Months

6. Notes:_____

_____

_____

_____

_____