Welcome

Thank you for choosing Newton Cosmetic Dentistry! To help us perfect your smile with the best dental care possible, please fill out this form completely in ink. If you have any questions, we'll be happy to help.

Patient Information *(Confidential)*

Date: ______________________

Patient Name: ____
(Last) *(First)* *(Middle)* *(Home Phone #)*

Email Address: ____
(Cell Phone #)

Address: ____
City *State* *Zip*

Place of Employment: ______________________ **Occupation:** ______________

Business Address: ____
City *State* *Zip* *Business Phone #*

Date of Birth: __________ **SS#:** __________ **Male:** ____ **Female:** ____

Height: Ft ___ In ___ Weight # ____ **Marital Status:** Single ____ Married ____ Divorced ____ Widowed ____

Hobbies: ____

Spouse Name: ______________________ **Date of Birth:** ______________

Place of Employment: ______________________ **Occupation:** ______________

Business Address: ____

Person responsible for the account: ____
Add address if different from above

Whom may we thank for referring you to our office? ______________________

Has any member of your family been to our office previously? Y ___ N ___ Relationship: __________

Why did you choose Newton Cosmetic Dentistry? ______________________

Please complete the following confidential information regarding DENTAL insurance.

Primary Carrier Insurance Company: ______________________

Mailing Address: ______________________

Insured's Name: ______________ **SS#:** ______________ **Group #:** ________

Secondary Carrier Insurance Company: ______________________

Mailing Address: ______________________

Insured's Name: ______________ **SS#:** ______________ **Group #:** ________

Dental History

Dental Health: Excellent ☐ Good ☐ Fair ☐ Poor ☐

What priority do you give your teeth *(10 being the highest)*? 1 2 3 4 5 6 7 8 9 10

Reason for today's visit? __________

Former Dentist: __________

City/State: __________

Date of last dental visit: __________

Date of last dental X-rays: __________

Mark "Y" or "N" if you have had any of the following:

Condition	Y	N
Bad Breath	☐ Y	☐ N
Bleeding Gums	☐ Y	☐ N
Blisters on lips or mouth	☐ Y	☐ N
Burning sensation on tongue	☐ Y	☐ N
Chew on one side of mouth	☐ Y	☐ N
Cigarette, pipe, or cigar smoking	☐ Y	☐ N
Clicking or popping jaw	☐ Y	☐ N
Dry mouth	☐ Y	☐ N
Fingernail biting	☐ Y	☐ N
Food collection between teeth	☐ Y	☐ N
Frequent head aches	☐ Y	☐ N
Clench or grind your teeth	☐ Y	☐ N
Gums swollen or tender	☐ Y	☐ N
Lip or cheek biting	☐ Y	☐ N
Loose teeth or broken fillings	☐ Y	☐ N
Mouth breathing	☐ Y	☐ N
Mouth pain, brushing	☐ Y	☐ N
Orthodontic treatment	☐ Y	☐ N
Pain around ear	☐ Y	☐ N
Periodontal treatment	☐ Y	☐ N
Sensitivity to cold	☐ Y	☐ N
Sensitivity to heat	☐ Y	☐ N
Sensitivity to sweets	☐ Y	☐ N
Sensitivity when biting	☐ Y	☐ N
Sores or growths in your mouth	☐ Y	☐ N

How often do you floss? __________

How often do you brush? __________

Do you like your smile? __________

Have you had any head, neck or jaw injuries? __________

Authorization and Release

I certify that I have read and understood the above information to the best of my knowledge. The above questions have been accurately answered, as providing incorrect information could be dangerous to my health. I authorize Newton Cosmetic Dentistry to release records of any treatment or examination rendered to me or my child to third-party payors and/or health practitioners. I authorize and request my insurance company pay directly to Newton Cosmetic Dentistry. I understand that my dental insurance carrier may pay less than the actual bought services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature: ______________________________

Date: ______________________________

MEDICAL HISTORY

PATIENT NAME ______________________________ Birth Date ______________________

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.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: ______________________
Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: ______________________
Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: ______________________
Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: ______________________
Do you take, or have you taken, Phen-Fen or Redux? ◯ 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? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics
☐ Other If yes, please explain: ______________________

Do you have, or have you had, any of the following?

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

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes, please explain: ______________________

Comments: ____
____
____
____
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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 ______________________________ DATE ______________

Newton Cosmetic Dentistry

190 Edgewood Avenue | Clinton TN, 37716 | (865) 457-0326

Written Financial Policy

Thank you for choosing Newton Cosmetic Dentistry. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:

You can choose from:

- Mastercard, Discover Card, Cash or Check, Visa

We offer a 5% courtesy accounting adjustment to patients who pay for their treatment with check or cash prior to completion of care for treatment plans of $5,000 or more.

- NO INTEREST[1] Payment Plans[2] from CareCredit
  - Allow you to pay over time with NO INTEREST[1]
  - Convenient, low monthly payment plans[2] also available
  - No annual fees or pre-payment penalties

Please note:

Newton Cosmetic Dentistry requires payment prior to the beginning of your treatment. If you choose to discontinue care before treatment is complete, your refund will be determined upon review of your case.

For plans requiring more than 4 appointments, alternative payment arrangements may be provided.

For patients with dental insurance we are happy to work with your carrier to maximize your benefit and provide you with the documentation you need to receive reimbursement for your treatment.

Newton Cosmetic Dentistry charges $25 for returned checks.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

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Patient, Parent or Guardian Signature Date

____

Patient Name (Please Print)

[1]If paid within the promotional period. Otherwise, interest assessed from purchase date. Minimum monthly payment required.

[2]Subject to credit approval