NESBIT CENTER OF DENTAL EXCELLENCE 956 Chandler Court, Waldorf, Maryland 20602 ______________________________

Phone: 301.705.9737 Fax: 301.893.2194

NEW PATIENT REGISTRATION FORM

*Welcome to **Nesbit Center of Dental Excellence**!*

To assist us in serving you, please complete the following confidential new patient form.
The information provided is important to your dental health. Thank you!

Today's Date ________________

PATIENT INFORMATION

INSURANCE/PAYMENT INFORMATION

AUTHORIZATION

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care. I authorize the release of any information concerning my (or my child's) health care, advice, and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I authorize the release of any information concerning my (or my child's) health care, advice and treatment to another dentist. I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me. I understand that my dental care insurance carrier or payer of my dental benefits may pay less than the actual bill for services. I understand I am financially

responsible for payments in full of all accounts. By signing this statement, I agree to be responsible for payments of services not paid, in whole or in part by my insurance. I attest to the accuracy of the information on this page.

Signature ____

Date_________________________________

DENTAL HEALTH HISTORY

Reason for Today's Visit

____

Date of last dental care_________ What was done at that time?

____ Date of last dental X-rays ___________Date of last cleaning__________Date of last oral cancer screening________________

Former Dentist ________________________ Phone number

____

Why did you leave your previous dentists?

____ Check (✓) if you have had problems with any of the following:

Have you had a serious/difficult problem associated with any previous dental treatment? ! Y ! N, If yes, please explain:

____

____

Have you ever had a bad experience at the dentist? ! Y ! N If yes, please explain:

____

____

Have you ever had an allergic reactions to Novocaine, local or general anesthetics? ! Y ! N If Yes, please explain:

____

____

Do you feel nervous about going to the dentist? ! Y ! How often do you floss?_________How often do you brush?

____

How do you feel about the appearance of your teeth?

____

MEDICAL HEALTH HISTORY

Check (ف) if you have or have had any of the following: (Please check any that apply)

Are you taking any of the following?

Are you under a Physician's Care? If so, for what?

____

Physicians Name: _________________________________ Physicians Phone Number:

____

Physicians Address:

____

Have you had any hospitilizations? If so what for, and when?

____

Do you have any disease, condition, or problem not listed above?

____

____

____

Please add anything else you would like us to know about:____

AUTHORIZATION AND RELEASE

I have read and answered the above questions to the best of my knowledge.

Patient/Guardian Signature: ____ Date: _____________

Reviewed by: ____ Date: _____________