

## New Patient Registration

Dr Shi and staff are pleased to welcome you to our dental practice. We will do everything possible to help you with your dental needs, and to alleviate your stress and fear of seeking dental treatment. Please fill out the following forms as completely as possible so we can provide quality dental care in a manner that is compatible with your general health. Incorrect or missing health information can be dangerous to your treatment. We will be glad to help you if you have any questions.

First Name: \_\_\_\_\_ Middle Initial \_\_\_\_ Last Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Sex \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_  
Phone Numbers: Home \_\_\_\_\_ Cell \_\_\_\_\_ Work \_\_\_\_\_  
Soc Sec No. \_\_\_\_\_ (Prepayment required if SS# is not provided)  
Email: \_\_\_\_\_@ \_\_\_\_\_  
Legal Guardian's Name (if minor) \_\_\_\_\_ Phone Number \_\_\_\_\_  
Address \_\_\_\_\_  
Who referred you here? \_\_\_\_\_ (name)

### Dental History Form

Reason for today's visit \_\_\_\_\_ When was the last time you visited a dentist? \_\_\_\_\_  
When was the last dental cleaning? \_\_\_\_\_ Last Full Mouth Xrays? \_\_\_\_\_  
What other concerns do you have about your oral condition (circle or list)? (toothaches, gum bleeding, tooth sensitivity to hot or cold, jaw joint clicking, bad breath, stained teeth, crooked teeth, and others problems: \_\_\_\_\_)  
Do you have any special concerns regarding your dental visit (circle or list)? (fear, time, cost, other \_\_\_\_\_)

### Payment Options

1. Self: Cash \_\_\_\_\_ Check \_\_\_\_\_ Other \_\_\_\_\_
2. Insurance:  
Name of Insurance Company \_\_\_\_\_  
Address \_\_\_\_\_  
Tel \_\_\_\_\_  
Insured Name \_\_\_\_\_  
Insured DOB \_\_\_\_\_ SS# \_\_\_\_\_  
Insured Address (if different from yours) \_\_\_\_\_
3. Other Payer: Name \_\_\_\_\_, SS# \_\_\_\_\_  
Address \_\_\_\_\_  
Phone Numbers \_\_\_\_\_

The above information and that of the attached health history form is correct to the best of my knowledge. I understand that this information will be held in the strict confidence. I authorize Dr Shi or his associates to perform any necessary diagnosis and treatment with my informed consent. I agree to pay the required fees for the services rendered.

Signed (Adult patient or legal guardian if minor) \_\_\_\_\_ Date \_\_\_\_\_