Centre Dental---John Shi DDS PC
139 Centre St, #306, New York, NY 10013
Ph: 212-925-7066 Email: Drshidental@gmail.com
www.Drshi.com

New Patient Registration

Dr Shi and staff at Centre Dental 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.

Section 1. Patient Information

First Name Last Name Middle Initial Date of Birth *(month/day/year)* Sex

_____|_____|_____|_____|_____

Address _____ City _____ State _____ Zip _____

Phone Numbers: Home _____ Cell _____ Work _____

SSN _____ (Prepayment required if SSN is not provided) Email: _____

Legal Guardian's Name (if minor) _____ Phone _____Address _____

Emergency Contact: Name _____ Phone _____ Who referred you to us? Name_____

Section 2. Dental History

Reason for today's visit _____When was the last time you visited a dentist? _____

When was the last dental cleaning? _____ Last Full Mouth X-Rays? _____

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 _____)

Section 3. Payment Options

1. Self: ☐ Cash ☐ Check Other _____

2. Insurance: Name of Insurance Company _____

   Address _____ Tel_____

   Insured Name _____ Insured DOB _____ Insured ID _____

   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.

Signature (Adult patient or legal guardian if minor) _____ Date *(month/day/year)* _____