## **New Patient Registration**

Section 1. Patient Information    First Name  Last Name  Middle Initial  Date of Birth (month/day/year)  Sex	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.							
Address	Section 1. Patient Info	ormation						
Address	First Name	Last Name	Middle Initial		Date of Birth (month/day/year)	Sex		
Phone Numbers: Home (Prepayment required if SSN is not provided) Email:    SSN (Prepayment required if SSN is not provided) Email:    Legal Guardian's Name (if minor) PhoneAddress    Ermergency 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?    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:							_	
SSN	Address			_City_	State	Zip	-	
Legal Guardian's Name (if minor)  Phone Address    Emergency Contact: Name  Phone  Who referred you to us? Name    Section 2. Dental History	Phone Numbers: Home _		Cell		_ Work	_		
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?    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:	SSN	(Prepayment	nt required if SSN is not p	provided	Email:		_	
Section 2. Dental History    Reason for today's visit	Legal Guardian's Name (	if minor)	Phone		Address			
Reason for today's visit	Emergency Contact: Nam	ne	Phone	Wh	o referred you to us? Name		_	
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:	Section 2. Dental Hist	ory						
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:	Reason for today's visit When was the last time you visited a dentist?							
cold, jaw joint clicking, bad breath, stained teeth, crooked teeth, and others problems:	When was the last dental cleaning? Last Full Mouth X-Rays?							
	What other concerns do y	ou have about your	oral condition (circle or li	st)? (too	thaches, gum bleeding, tooth sensi	itivity to hot or		
Section 3. Payment Options    1. Self:  Cash  Check  Other	cold, jaw joint clicking, b	ad breath, stained te	eth, crooked teeth, and ot	hers prot	lems:			
Section 3. Payment Options    1. Self:  Cash  Check  Other							)	
1. Self:  Cash  Check  Other    2. Insurance: Name of Insurance Company	Do you have any special concerns regarding your dental visit (circle or list)? (fear, time, cost, other							
2. Insurance: Name of Insurance Company	Section 3. Payment O	ptions						
Address  Tel	1. Self: 🔲 Cash		Other					
Insured Name  Insured DOB  Insured ID    Insured Address (if different from yours)	2. Insurance: Name of Ins	surance Company						
Insured Address (if different from yours)	Address				Tel			
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.	Insured Name		Insured D	OB	Insured ID			
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.	Insured Address (if dif	ferent from yours) _						
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.	3. Other Payer: Name		SS#		_			
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treatment with my informed consent. I agree to pay the required fees for the services rendered.							is	
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Signature (Adult patient or legal guardian if minor) Date (month/day/year)	ireaiment with my injorn	nea consent. 1 agree	e w pay ine requirea jees	jor the s	ervices renuereu.			
	Signature (Adult patient o	or legal guardian if n	ninor)		Date (month/day/year)		_	