NEW PATIENT REGISTRATION

1. PATIENT INFORMATION

LAST NAME	FIRST	MI	PREFERS TO BE CALLED
☐ Male ☐ Female	MARITAL STATUS	BIRTHDATE	SOCIAL SECURITY NUMBER
ADDRESS			
CITY		STATE	ZIP
HOME PHONE		WORK PHONE	
CELL PHONE		FAX	

2A. PRIMARY DENTAL INSURANCE

INSURANCE COMPANY	GROUP NO.	MEMBER ID.
INSURED'S NAME	BIRTHDATE	RELATIONSHIP
INSURED'S ID NO.	INSURED'S SOCIAL SECURITY NUMBER	

2B. SECONDARY DENTAL INSURANCE

INSURANCE COMPANY	GROUP NO.	MEMBER ID.
INSURED'S NAME	BIRTHDATE	RELATIONSHIP
INSURED'S ID NO.	INSURED'S SOCIAL SECURITY NUMBER	

2C. DSHS INSURANCE

Do you have DSHS or Provider One insurance? ☐ No ☐ Yes, ID: _____

3. FINANCIAL INFORMATION

Are you financially responsible for this account? ☐ Yes

If not 'Yes', please tell us who is responsible for your account:

NAME	BIRTHDATE	RELATIONSHIP
ADDRESS		
CITY	STATE	ZIP
PHONE NUMBER		

4A. EMERGENCY CONTACT

NAME	RELATIONSHIP
PHONE NUMBER	
ADDRESS	
CITY	STATE ZIP

4B. YOUR SPOUSE

NAME	PHONE NUMBER

5. CONSENT FOR SERVICES

- Payment for services must be made at the time services are performed. I authorize and request New Day Dental Care to bill my insurance as a courtesy and for my insurance company to pay directly to the clinic. If any balance is unpaid, or if I do not have any insurance, then any balance due is my responsibility.
- I consent to New Day Dental Care the use and disclosure of my protected health information to carry out treatment and healthcare operations that I may need during diagnosis and treatment. I authorize the clinic to release any information and records of any treatment to third party payors and/or health practitioners.
- I may request a copy of New Day Dental Care's NOTICE OF PRIVACY PRACTICES at any time.

I have read the above conditions and agree to their content.

Sign: _____ Date: _____

Please turn over and complete the other side.

NEW PATIENT REGISTRATION

6. AFFIDAVIT AND DECLARATION OF HOUSEHOLD SIZE AND INCOME
Used for the purpose of qualifying for discounted services from New Day Dental Care.

Number of people in your household: _____

Gross income and frequency: _____
Total received from all sources, before taxes and deductions

Total income received in the prior year: _____
Total received from all sources, before taxes and deductions

I am declaring that the information and amounts on this form are correct and accurate to the best of my knowledge. This information is being used to calculate the amount of discount (if any) on services from the Clinic. I understand that providing incorrect or misleading information on this form for the purpose of receiving a discount is considered fraud and theft of services and may result in action being taken, up to including collection of additional fees for services rendered, exclusion for receiving further services from the Clinic, or criminal prosecution.

I also understand that I am responsible for notifying the Clinic of any change in this information prior to having any services performed.

The Clinic may request documentation to verify this information, including paystubs and/or tax returns, and I provide my authorization for release of this documentation to the Clinic.

_____ _____
Signature *Date*

No show Policy

New Day Dental Care wants to make sure that you and other area residents have access to high-quality dental care when you need it. To ensure maximum access to dental services for all our patients, please be aware of the following Appointment Policy:

Scheduled Appointments: Although we will make every effort to remind you of your upcoming dental appointment by phone, you are ultimately responsible for remembering your appointment date and time.

Canceling Appointments: If you cannot make your scheduled appointment, you must call us at least 24 hours in advance to let us know so that we can offer your appointment to another patient.

Please talk to any of the dental staff if you have questions about our no show policy.

I understand and agree to abide by this no show policy.

Initials:_____ Date: _____