SCOTT D. NEWLIN, D.M.D., M.S., P.C.

We welcome you to our office. Please fill in this questionnaire. Thank you!

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive and maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use information to discriminate.

Name			Nickname:
Home Address		EMAIL:	
City		State	Zip code
Birthdate	SS#	Driver's License #	
Phones	Home # ( )	Work # ( )	Cell # ( )
Spouse or Guardian			
Name of General Dentist/Referring Dentist			Pharmacy # ( )
Emergency contact:	Home # ( )		Cell # ( )
Who is responsible for payment of this account?			
If you are completing this form for another person, what is your relationship to that person?			

OUR PAYMENT POLICY

The best patient-doctor relationships are maintained when there is a complete understanding of the treatment rendered and the fee. Please feel free to discuss the treatment and/or fee at any time. OUR POLICY IS PAYMENT AT TIME SERVICES ARE RENDERED, UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE.

Please check how you will be paying:	☐ cash/check	☐ MC/Visa	☐ AMEX	☐ Discover	☐ Care Credit
FEES ESTIMATE	Limited Evaluation $145	Anterior RCT $1211-1745	Bicuspid RCT $1478-1905	Molar RCT $1842-2861	

I understand Root Canal Therapy is a procedure to retain a tooth which may otherwise require extraction. Although Root Canal Therapy has a very high degree of clinical success, it is still a biological procedure, so it cannot be guaranteed. Occasionally, a tooth which has had Root Canal Therapy may require retreatment, surgery, or even extraction. I also understand that only the Root Canal Therapy is to be performed at this office. The permanent restoration (filling, onlay, crown, etc.) will be done by my regular dentist. I acknowledge that I am responsible for charges not covered by my insurance. **Initials:**_____

MEDICAL HISTORY

(please mark (X) your responses for the following questions)

Are you now under the care of a physician?	
Physician's name:	Phone:
Women only; Pregnant? Nursing?	Taking birth control or hormonal replacement?

Are you taking or have you recently taken any prescription or over the counter medicine? **YES / NO** If yes, please list them here:
*** ARE TAKING BLOOD THINNERS? **YES / NO**
*** ARE YOU TAKING OR SCHEDULED TO BEGIN TAKING ANY OF THESE MEDICATIONS: ALENDRONATE (FOSAMAX®), DENOSUMAB (PROLIA®, XGEVA®), OR RISEDRONATE (ACTONEL®) FOR OSTEOPOROSIS OR PAGET'S DISEASE? **YES / NO**
*** SINCE 2001, WERE YOU TREATED OR ARE YOU PRESENTLY SCHEDULED TO BEGIN TREATMENT WITH THE INTRAVENOUS BISPHOSPHONATES(AREDIA® OR ZOMETA®) FOR BONE PAIN, HYPERCALCEMIA OR SKELETAL COMPLICATIONS RESULTING FROM PAGET'S DISEASE,MULTIPLE MYELOMA OR METASTATIC CANCER? **YES / NO**
Women only; **Pregnant?** **Nursing?** Taking birth control or hormonal replacement?

ALLERGIES – Are you allergic to or have you had a reaction to:
To all yes responses, specify type of reaction.

	YES	NO	?		YES	NO	?
Local anesthetics				Metals			
Aspirin				Latex (rubber)			
Penicillin				Iodine			
Sulfa drugs				Barbiturates, sedatives or sleeping pills			
Other antibiotics:				Codeine or other narcotics			
Tylenol				Other:			
Do you have to be PRE-MED for dental procedures? If yes, Why?							
Name of the dentist or physician making recommendation:				Phone ( )			

Please circle any following disease or problems you have or have had:

Heart problems/disease	Herpes	Stroke
Previous infected endocarditis	Diabetes Type I or II	Hepatitis, jaundice or liver disease
High blood pressure	Thyroid problems	Arteriosclerosis
Pacemaker	Joint replacement	Tuberculosis
Osteoporosis	Ulcers	Arthritis
Respiratory problems / Asthma	Hemophilia	Severe migraines / headaches
Cancer / chemotherapy / radiation treatment	AIDS or HIV infection	Chronic pain
Rheumatoid arthritis	Autoimmune disease	Epilepsy
Previous MRSA infection / carrier	Persistent swollen glands in neck	Gastrointestinal disease
Abnormal bleeding	Glaucoma	Sexually transmitted disease
Kidney problems	Fainting spells or seizures	Neurological disorders

Do you have any disease, condition, or problem not listed above that you think we should know about? _____
If yes, please explain: _____

NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.
I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a trustful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.
SIGNATURE OF PATIENT/LEGAL GUARDIAN: Date: / /
For completion by dentist
Signature of the Doctor and Comments:

SCOTT D. NEWLIN, D.M.D., M.S., P.C.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign this Acknowledgement

I, _____, have reviewed a copy of this office's Notice of Privacy Practices. The Notice if Privacy Practices is also available on www.newlinendodontics.com.

_____

Please Print Name

_____ / /

Signature – self or guardian Date

PLEASE CHECK ALL THAT APPLY:

Home phone #		Leave detailed message		Leave message to call back
Cell phone #		Leave detailed message		Leave message to call back

I GIVE CONSENT TO DR. SCOTT NEWLIN'S OFFICE TO RELEASE AND/OR DISCUSS DETAILS OF MY DENTAL CARE, INCLUDING MEDICATIONS, APPOINTMENTS, AND OTHER INFORMATION WITH THE PERSONS LISTED BELOW:

Name	Relationship	Phone Number

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because…..

_____Individual refused to sign.
_____Communication barriers situation prevented us from obtaining the acknowledgement.
_____An emergency situation prevented us from obtaining acknowledgement.
_____Other - Please Specify: _____.

THIS DOCUMENT WILL BE A PART OF YOUR DENTAL RECORD