John Aurelia, DDS
Dina Khoury, DDS

New Patient Registration Form

Patient Name: _____ _____ _____
First name Middle name Last name

Patient Date of Birth: _____/_____/_____ Age: _____ Marital Status: _____ Sex: _____

Address: _____ Zip Code: _____

Email Address: _____

Cell Phone #: _____ Home or Secondary Phone #: _____

Patient Health Information

Date of Last Dental Visit: _____/_____/_____ Reason for this visit: _____

Have you ever had any of the following? Please check all that apply:

- ☐ AIDS/HIV
- ☐ Allergies: Drug List_____
- ☐ Allergies: Other List _____
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints Date _____
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer Type_____
- ☐ Chemotherapy
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Fainting
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Head Injury
- ☐ Heart Attack Date_____
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorder
- ☐ Nervous Disorder
- ☐ Pacemaker
- ☐ Current Pregnancy
- ☐ Radiation Tx
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Thyroid
  - ○ Hypo
  - ○ Hyper
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Other List_____

*Please list current medications: _____

*Please explain any health issues that need further clarification: _____

_____

*Please explain any complications the patient has had following dental treatment: _____

*Has the patient been admitted to the hospital or needed emergency care during the past two years? If so, please explain:

_____

*Is the patient now under the care of a physician? If yes, please explain: _____
Name of physician: _____ Phone: _____

☐ ***To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.***

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Responsible Party Information

The following information is for the person responsible for the payment of services

Patient Name: _____ _____ _____
First name Middle name Last name

Patient Date of Birth: _____/_____/_____ Age: _____ Marital Status: _____ Sex: _____

Address: _____ City: _____ State: _____ Zip _____

Cell phone#: _____ Alternate Phone#: _____

Dental Insurance Information

Please note that this Insurance may be different than your medical insurance carrier

Primary Insurance

Name of Subscriber: _____ _____ _____
First name Middle name Last name

Subscriber's Birth Date: ____/____/____ Insured Subscriber's Employer Name: _____

Insurance Carrier Name: _____ Insurance Carrier Provider Phone#: _____

Policy ID# (or SSN): _____ Group # _____

Claims Mailing Address: _____

Patient's relationship to Insured Subscriber: _____

Secondary Insurance

Name of Subscriber: _____ _____ _____
First name Middle name Last name

Subscriber's Birth Date: ____/____/____ Insured Subscriber's Employer Name:_____

Insurance Carrier Name: _____ Insurance Carrier Provider Phone#: _____

Policy ID# (or SSN): _____ Group # _____

Claims Mailing Address: _____

Patient's relationship to Insured Subscriber: _____

Referral Information

Whom may we thank for referring you to our practice?

☐ Another patient, friend ☐ Another patient, relative ☐ Dental office ☐ Online search ☐ Work ☐ School ☐ Other List _____

Name of person or office referring you to our practice: _____

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Consent for Services

As a condition of treatment by this office, patients are expected to pay their balance at the time of service, or to make financial arrangements in advance. The practice depends upon the reimbursement from patients for the costs incurred in their care, and financial responsibility on the part of each patient must be determined before treatment.

As a courtesy, for those patients who carry dental insurance, the practice will send claims to the patient's insurance company first. We will then send a statement for any remaining balance to the responsible party. This office cannot render services on the assumption that our charge will be paid by an insurance company. We ask that all patients update us immediately with any changes to insurance coverage.

A late fee or service charge of 1.5% per month (18% annum) on the unpaid balance, or $10.00 minimum per month may be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit shall be instituted hereunder.

☐ I have read the above conditions of treatment and payment and agree to their content.

☐ I grant my permission to you or your assignee to telephone me at home, or by mobile phone, or at my work to discuss matters related to this form.

☐ I grant my permission to you or your assignee to communicate with me electronically at the email address provided. I am aware that there is some level of risk that third parties might be able to read unencrypted emails. I am responsible for providing the dental practice any updates to my email address. I can withdraw my consent to electronic communications at any time by calling 248-651-6810.

☐ I have read this practice's Financial Policy and agree to its terms and conditions.

☐ I have read this practice's Notice of Privacy Practices and agree to its terms and conditions.

_____ _____/_____

Signature of patient, parent or guardian | Relationship to patient | Date

_____ _____/_____

Signature of guarantor of payment/responsible party | Relationship to patient | Date

_____ _____

Dentist's signature | Date

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Dina Khoury, DDS

Radiograph and Records Request

Please complete this form only to request records from a previous dental office.

Dear Doctor,

Please accept this document as my formal request to have my most recent radiograph and dental records forwarded to the practice of Dr. John L. Aurelia and Dr. Dina Khoury at the following location:

John L. Aurelia, D.D.S., PLLC
804 North Main Street, Suite 201-A
Rochester, Michigan 48307

Email: frontdesk@aureliadds.com

Thank you for your assistance in this matter.

Patient's (Printed) Name

Patient's Date of Birth

Patient's Signature

Date

Previous Dentist's Name

Previous Dentist's Phone #

Previous Dentist's Fax #