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)* ___________________