The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain optimal oral health. Please fill out this form completely. The better we communicate, the better we can care for you.

About You

Today's Date: _____

E-mail Address: _____

Name: _____
Last First MI Mr. Mrs. Ms. Dr.

I prefer to be called: _____ ☐ Male ☐ Female

Birthdate: ___/___/___ Age: ____ SS#: _____

Home Address: _____
Apt/Condo #

_____
City State Zip

☐ Single ☐ Married ☐ Partnered ☐ Divorced/Separated ☐ Widowed

Hm #: (____)_____ Cell #: _____

Wk #: (____)_____ Ext: ____ DL #: _____

Employer: _____

Employer's Address: _____

_____
City State Zip

How long there? _____ Occupation: _____

Where & when are best times to reach you? _____

Whom may we Thank for referring you? _____

Other family members seen by us: _____

Previous / Present Dentist: _____
[Previous Dentist]

Person Responsible for Account: _____

Spouse Information

His / Her Name: _____

Employer: _____

Wk #: (____)_____ Ext: ____ SS #: _____

Birthdate: ___/___/___ DL #: _____

Relative or Friend not living with you (for emergency).

His / Her Name: _____ Relation: _____

Wk #: (____)_____ Hm #: (____) _____

Insurance

Primary Insurance

Dental Coverage? ☐ Yes ☐ No

Insurance Co. Name: _____

Insurance Co. Address: _____

_____
City State Zip

Insurance Co. Phone #:(____) _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: ___/___/___ Insured's ID #: _____

Insured's Employer: _____

Employer's Address: _____

_____
City State Zip

Secondary Insurance

Dental Coverage? ☐ Yes ☐ No

Insurance Co. Name: _____

Insurance Co. Address: _____

_____
City State Zip

Insurance Co. Phone #:(____) _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: ___/___/___ Insured's ID #: _____

Insured's Employer: _____

Employer's Address: _____

_____
City State Zip

Payment is due in full at the time of treatment
unless prior arrangements have been approved.

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

_____
Signature Date

Continued on Back

Medical History

Do you have a personal physician? ☐ Yes ☐ No

Physician's Name: _____

Phone #: (___) _____ Date of last visit: _____

Your current physical health is: ☐ Good ☐ Fair ☐ Poor

Are you currently under the care of a physician? ☐ Yes ☐ No

Please explain: _____

Do you smoke or use tobacco in any other form? ☐ Yes ☐ No

Have you had any metal rods, pins or implants? ☐ Yes ☐ No

Are you taking any prescription / over-the-counter drugs? ☐ Yes ☐ No

Please list each one: _____

Have you ever taken Fosamax, or any other bisphosphonate? ☐ Yes ☐ No

Have you been told that you snore or hold your breath while sleeping or wake up gasping for breath? ☐ Yes ☐ No

For Women: Are you using a prescribed method of birth control? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No Week #: _____

Are you nursing? ☐ Yes ☐ No

Have you ever had any of the following diseases or medical problems

Y	N	Abnormal Bleeding / Hemophilia	Y	N	Herpes / Fever Blisters
Y	N	AIDS	Y	N	High Blood Pressure
Y	N	Alcohol / Drug Abuse	Y	N	HIV
Y	N	Anemia	Y	N	Hospitalized for Any Reason
Y	N	Arthritis	Y	N	Kidney Problems
Y	N	Artificial Bones / Joints / Valves	Y	N	Liver Disease
Y	N	Asthma	Y	N	Low Blood Pressure
Y	N	Blood Transfusion	Y	N	Lupus
Y	N	Cancer / Chemotherapy	Y	N	Mitral Valve Prolapse
Y	N	Colitis	Y	N	Pacemaker
Y	N	Congenital Heart Defect	Y	N	Psychiatric Treatment
Y	N	Diabetes	Y	N	Radiation Treatment
Y	N	Difficulty Breathing	Y	N	Rheumatic / Scarlet Fever
Y	N	Emphysema	Y	N	Seizures
Y	N	Epilepsy	Y	N	Shingles
Y	N	Fainting Spells	Y	N	Sickle Cell Disease / Traits
Y	N	Frequent Headaches	Y	N	Sinus Problems
Y	N	Glaucoma	Y	N	Stroke
Y	N	Hay Fever	Y	N	Thyroid Problems
Y	N	Heart Attack / Surgery	Y	N	Tuberculosis (TB)
Y	N	Heart Murmur	Y	N	Ulcers
Y	N	Hepatitis	Y	N	Venereal Disease

Please list any serious medical condition(s) that you have ever had:

_____

_____

Are you allergic to any of the following?

Y	N	Aspirin	Y	N	Erythromycin	Y	N	Penicillin
Y	N	Codeine	Y	N	Jewelry/Metals	Y	N	Tetracycline
Y	N	Dental Anesthetics	Y	N	Latex	Y	N	Other

Please list any other drugs/materials that you are allergic to: _____

_____

Dental History

Why have you come to the dentist today? _____

_____

Are you currently in pain? ☐ Yes ☐ No

Do you require antibiotics before dental treatment? ☐ Yes ☐ No

Your current dental health is: ☐ Good ☐ Fair ☐ Poor

Have you ever had a serious / difficult problem associated with any previous dental work? ☐ Yes ☐ No

Do you floss daily? ☐ Yes ☐ No Brush daily? ☐ Yes ☐ No

Type of bristles on your toothbrush? ☐ Hard ☐ Medium ☐ Soft

Have you ever had gum treatment? ☐ Yes ☐ No

Do your gums ever bleed? ☐ Yes ☐ No Ever Itch? ☐ Yes ☐ No

Have you ever had periodontal disease? ☐ Yes ☐ No

Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)? ☐ Yes ☐ No

Are your teeth sensitive to heat, cold, or anything else? _____

Do you have any loose teeth? ☐ Yes ☐ No

Do you still have wisdom teeth? ☐ Yes ☐ No

Would you like fresher breath? ☐ Yes ☐ No Whiter teeth? ☐ Yes ☐ No

Are you happy with the way your smile looks? ☐ Yes ☐ No

If not, what would you change? _____

_____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment, with my informed consent.

_____

Signature Date

Office Use Only Office Use Only

I verbally reviewed the medical / dental information with the patient named herein.

Initials: _____ Date: _____

Doctor's Comments: _____

_____

_____

_____

_____

Our office is HIPAA Compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

Medical History Update

Has there been any change in your health status since your last visit? Y N

If Yes, please explain. _____

_____ Patient Signature Date

_____ Dentist Signature Date

Has there been any change in your health status since your last visit? Y N

If Yes, please explain. _____

_____ Patient Signature Date

_____ Dentist Signature Date

DOWNTOWN CONCORD DENTAL

Thank you for choosing Downtown Concord Dental. Please take the time to fill out this form so that we may better serve you.

Name **Phone number** **Cell Phone #**

_____ ( ) _____ ( ) _____

We are going green! Downtown Concord Dental has always been committed to making the world a healthier place. We've now expanded that outlook beyond your personal dental health by shifting to paperless communications. Downtown Concord Dental offers email service to remind you when you need a check up as well as confirmation of your appointments.

Email Address:_____

How would you prefer to be reminded of your appointment?
Text message [ ] Email [ ] Phone call [ ]

How did you find out about our office?
Check all that apply:

1. [ ] Friends or Family, Name:_____
2. [ ] Yellow Pages
3. [ ] Penny Saver
4. [ ] Saw the location of the office
5. [ ] Phone Referral
6. [ ] Insurance Carrier
7. [ ] Employees I work with, Name:_____
8. [ ] Yelp
9. [ ] Google

Welcome to Downtown Concord Dental!

We would like to welcome you to our Dental Practice and look forward to providing you with all your dental needs. Here are some of our office policies so that we may insure a professional relationship for years to come.

Our Financial Policy:

Payment is due at the time of service unless other arrangements have been made. We offer several options of payment for your convenience: cash, check, Visa, MasterCard. We believe that patients who do not have available funds or insurance should not have to delay treatment due to money, that is why we have partnered with Care Credit. This company allows our patients, who qualify, the opportunity to spread out the cost of treatment into small monthly payments. Any patients who would like to take advantage of this convenient option for payment will need to fill out an application: please ask the front desk for one. Also, a patient's account must be up to date, to start new treatment, unless other arrangements where made.

Usual & Customary Fees:

We are committed to providing excellent dental treatment to all of our patients. Our fees reflect our commitment to the quality our patients deserve and are considered usual and customary for the area.

Insurance:

As a courtesy service to our patients, we bill your insurance company after each visit. Insurance policies vary and services rendered may not be covered. Balance is the patient's responsibility whether your insurance pays or not. Our office is committed to helping our patients maximize their benefits.

Missed appointments:

We understand that occasionally our patients will need to reschedule their appointments. We do enforce that you call at least 48 hours before your appointment to reschedule or cancel, to avoid being charged a $50.00 cancellation fee.

Children under 18:

We require all children under the age of 18 to be accompanied by a parent or legal guardian. During the time the patient is in the office, we request the parent/guardian stay in the office as treatment may change or questions may arise that only the parent/guardian can answer.

Please sign below to acknowledge that you have read and understand our office policies. Thank you for you cooperation and we look forward in helping you with your dental needs.

Print Patient name:_____ Sign:_____

(Patient or Parent/Guardian if patient is a minor)

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgment****

I, _____, have received a copy of this office's Notice
(Patient Name)

of Privacy Practices.

_____
Signature (Patient or Parent/Guardian if Patient is a minor)

_____
Date

_____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices but acknowledgment could not be obtained because:

- ○ Individual Refused to sign
- ○ Communication barriers prohibited obtaining the acknowledgment
- ○ An Emergency situation prevented us from obtaining acknowledgment
- ○ Other, Please specify:_____