Patient Information

Name _____ Birthdate _____

☐Home Phone _____ ☐Work Phone _____ ☐Cell Phone _____
please check preferred contact number

Address _____ City_____ State _____ Zip _____

Email Address _____

Check Appropriate: ☐Minor ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated

Patient or Parent's Employer _____

Business Address _____ City _____ State _____ Zip _____

Spouse or Parent's Name _____

Employer _____ Work Phone _____

Whom may we thank for referring you? _____

Emergency Contact _____ Relationship _____ Phone _____

Responsible Party

Responsible Party for this account _____ Relationship to patient_____

Address _____ City _____ State _____ Zip _____

☐Home Phone _____ ☐Work Phone _____ ☐Cell Phone _____

Social Security # _____ Birthdate _____

Employer _____ Currently a patient in our office? ☐ YES ☐ NO

Insurance Information

Named of Insured _____ Relationship to patient _____

Social Security # _____ Birthdate _____

Employer _____ Address _____ City _____ State ____ Zip _____

Dental Insurance Company _____ ID # _____

Group # _____ Union or Local # _____

Address _____ City _____ State _____ Zip _____

Secondary Insurance Information

Named of Insured _____ Relationship to patient _____

Social Security # _____ Birthdate _____

Employer _____ Address _____ City _____ State ____ Zip _____

Dental Insurance Company _____ ID # _____

Group # _____ Union or Local # _____

Address _____ City _____ State _____ Zip _____

MEDICAL HISTORY

Patient Name _____ Date of Birth _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Primary Care Physician's Name _____ Physician's Telephone # _____

Are you under a physician's care now? ☐ Yes ☐ No If yes, please explain _____

Have you ever been hospitalized or had a major operation? ☐ Yes ☐ No If yes, please explain _____

Have you ever had a serious head or neck injury? ☐ Yes ☐ No If yes, please explain _____

Are you taking any medications, pills, or drugs? ☐ Yes ☐ No If yes, please list all medications, prescribed and over the counter

Do you use tobacco? ☐ Yes ☐ No _____

Do you use controlled substances? ☐ Yes ☐ No _____

Have you taken Fosamax, Boniva, Actonel or other meds with bisphosphonates? If yes, please explain _____

Are you on a special diet? ☐ Yes ☐ No If yes, please explain _____

Women: Are you… Pregnant/Trying to get pregnant? ☐Yes ☐No Nursing? ☐Yes ☐No Taking oral contraceptives? ☐Yes ☐No

Are you allergic to any of the following?

☐Aspirin ☐Penicillin ☐Codeine ☐Acrylic ☐Metal ☐Latex ☐Sulfa Drugs ☐Local Anesthetics

☐Other If yes, please explain _____

Please check if have had any of the following.

☐AIDS/HIV Positive
☐Alzheimer's Disease
☐Anaphylaxis
☐Anemia
☐Angina
☐Arthritis/Gout
☐Artificial Heart Valve
☐Artificial Joint
☐Asthma
☐Blood Disease
☐Blood Transfusion
☐Breathing Problem
☐Bruises Easily
☐Cancer
☐Chemotherapy
☐Chest Pains
☐Cold Sores/Fever Blisters
☐Congenital Heart Disorder
☐Convulsions
☐Cortisone Medicine
☐Diabetes
☐Drug Addiction
☐Easily Winded
☐Emphysema
☐Epilepsy or Seizures
☐Excessive Bleeding
☐Excessive Thirst
☐Fainting Spells/Dizziness
☐Frequent Cough
☐Frequent Diarrhea
☐Frequent Headaches
☐Genital Herpes
☐Glaucoma
☐Hay Fever
☐Heart Attack/Failure
☐Heart Murmur
☐Heart Pace Maker
☐Heart Trouble/Disease
☐Hemophilia
☐Hepatitis A
☐Hepatitis B or C
☐Herpes
☐High Blood Pressure
☐High Cholesterol
☐Hives or Rash
☐Hypoglycemia
☐Irregular Heartbeat
☐Kidney Problems
☐Leukemia
☐Liver Disease
☐Low Blood Pressure
☐Lung Disease
☐Mitral Valve Prolapse
☐Osteoporosis
☐Pain in Jaw Joints
☐Parathyroid Disease
☐Psychiatric Care
☐Radiation Treatments
☐Recent Weight Loss
☐Renal Dialysis
☐Rheumatic Fever
☐Rheumatism
☐Scarlet Fever
☐Shingles
☐Sickle Cell Disease
☐Sinus Trouble
☐Spina Bifida
☐Stomach/Intestinal Disease
☐Stroke
☐Swelling of Limbs
☐Thyroid Disease
☐Tonsillitis
☐Tuberculosis
☐Tumors or Growths
☐Ulcers
☐Venereal Disease
☐Yellow Jaundice

Have you ever had any serious illness not listed above? ☐Yes ☐No If yes, please explain _____

Comments _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ Date _____

Financial Policy

Thank you for choosing Concord Dental Group for your dental needs. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our financial policy, which we require you to read and sign prior to any treatment.

Full payment is due at time of service. We accept cash, check, Visa, MasterCard, Discover, and American Express. If financing is needed, Care Credit offers 6, 12, 18 and 24 month interest free finance options to those who qualify.

There is a $40.00 handling fee for any returned check. Attorney and collection fees incurred in an effort to enforce payment will be the responsibility of the patient/guarantor. Failure to sign this contract does not negate the responsible party from financial responsibility for any services that have been rendered, as a submission of treatment implies consent as outlined in the agreement. We reserve the right to charge interest in the amount of 1.5% as provided by state law.

FOR PATIENTS WITH INSURANCE: As a service to our patients, we will accept "assignment of benefits" and will bill your insurance carrier, provided all necessary insurance information is provided to our office at the time of service. Every effort will be made to closely estimate your co-payments and deductibles that are due at time of service. Account balances are your responsibility whether the insurance company pays or not. It is our office policy to collect all co-insurance deductibles and non-covered amounts at the time of service. Please understand that insurance coverage and benefits are contracted between you and your insurance company. If an insurance carrier has not paid within 60 days of service (regardless of reason), any unpaid professional fees are due and payable in full, from you. Once your carrier has paid the claim, any difference will be due upon receipt of our statement. Again, all account balances, regardless of insurance status, are due within 90 days of service.

ADULT PATIENTS: Adult patients are responsible for full payment at time of service.

MINOR PATIENTS: The adult accompanying a minor and the parents (or guardians of the minor) are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, Visa/MasterCard/Discover/American Express, or payment by cash or check at time of service has been verified.

USUAL AND CUSTOMARY RATE: Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary in our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. The fees we charge for dental services are the same for every patient, insured or not. A given insurance policy, however, is based on a fixed fee schedule - "usual and customary" - that may have nothing to do with the real world. Dentistry has changed very quickly, insurance fee schedules have not. After all, insurance companies are profitable businesses, not dental benefactors.

MISSED OR CANCELLATION OF APPOINTMENTS: Our goal is to provide high quality of care at low cost to our patients and in fairness to other patients and the doctor, we require at least 24 hours' notice when canceling an appointment. You will be responsible for a $25.00 fee for missed appointments without 24 hour notification. The practice reserves the right to dismiss patients with excessive canceled appointments.

I have read and understood the above financial policy for payment of professional fees. I understand and agree that I AM RESPONSIBLE FOR ALL FEES FOR SERVICES PROVIDED TO ME as outlined above.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ Date _____

Photo Consent

I grant full permission to Concord Dental Group to use either my photograph or my child's photograph to showcase before and after smiles on the Concord Dental Group website, Facebook page, and waiting room display book. I understand that no names will be attached to any photographs.

Full face photographs ☐ Yes ☐ No Teeth only photographs ☐ Yes ☐ No

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ Date _____