

Have you ever had?

- Orthodontic treatment? _____ Yes No
- Oral surgery? _____ Yes No
- Periodontal treatment? _____ Yes No
- Your teeth ground or bite adjusted? _____ Yes No
- A bite plate or mouth guard? _____ Yes No
- A serious injury to the mouth or head? _____ Yes No

Have you experience?

- Clicking or popping of the jaw? _____ Yes No
- Pain (joint, ear, side of face)? _____ Yes No
- Difficulty in opening or closing the mouth? _____ Yes No
- Difficulty chewing on either side of the mouth? _____ Yes No

Are your teeth sensitive to?

- Hot or cold? _____ Yes No
- Sweets? _____ Yes No
- Biting or chewing? _____ Yes No
- Mouth odor or bad tastes? _____ Yes No
- Do you get cold sores, blisters, or other oral lesions? _____ Yes No
- Do your gums bleed or hurt? _____ Yes No
- Have your parents had gum disease or tooth loss? _____ Yes No
- Notice any loose teeth or change in your bite? _____ Yes No
- Does your food tend to become caught between any teeth? _____ Yes No

Do You?

- Clench/grind teeth while awake or asleep? _____ Yes No
- Bite your lips or cheeks regularly? _____ Yes No
- Mouth breathe while awake or asleep? _____ Yes No
- Have tired jaws, especially in the morning? _____ Yes No
- Smoke/chew tobacco? _____ Yes No
- Sore muscles (neck, shoulders)? _____ Yes No

Would you like your smile analyzed? Yes No

If yes, is there a spouse or significant other you want to include in our discussion? Yes No

Signature of patient, parent or guardian

Date: _____

Referral Information

Whom may we thank for referring you to our practice? Another patient, friend Another patient, relative

Dental Office Yellow Pages Newspaper School Work Other _____

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

Medical History

Please indicate which of the following you have had or have at present:

- | | | |
|-------------------------------------|------------------------------|-----------------------------|
| 1. Tuberculosis | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. Asthma | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. Hay fever | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4. Latex sensitivity | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 5. Allergies/Hives | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 6. Sinus trouble | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 7. Heart (surgery/disease/attack) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 8. Chest pain | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 9. Congenital heart disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 10. Heart murmur | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 11. High blood pressure | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 12. Mitral valve prolapsed | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 13. Artificial heart valve | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 14. Heart pacemaker | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 15. Rheumatic fever | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 16. Arthritis/Rheumatism | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 17. Cortisone medicine | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 18. Swollen ankle | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 19. Stroke | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 20. Diet (special restricted) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 21. Kidney trouble | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 22. Thyroid problems | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 23. Ulcers | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 24. Diabetes | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 25. Glaucoma | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 26. Contact Lenses | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 27. Emphysema | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 28. Chronic Cough | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 29. Radiation therapy | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 30. Chemotherapy | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 31. Tumors | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 32. Hepatitis A (infectious) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 33. Hepatitis B (serum) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 34. Venereal disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 35. AIDS | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 36. HIV positive | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 37. Cold sores/Fever blisters | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 38. Blood transfusion | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 39. Hemophilia | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 40. Sickle cell disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 41. Bruise easily | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 42. Liver disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 43. Yellow jaundice | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 44. Neurological disorders | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 45. Epilepsy or seizures | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 46. Fainting or dizzy spells | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 47. Nervous/Anxious | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 48. Psychiatric Psychological care) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Women Only:

Are you pregnant? Yes ____Months No

Nursing? Yes No

Taking birth control? Yes No

Please Answer Following Questions:

Have you been under the care of a medical doctor during the past two years? Yes No

If yes, for what _____

Physician's name _____ Phone _____

Have you been a patient in the hospital during the past 5 years? Yes No

Have you or do you have any disease condition, or problem not listed above? Yes No

If yes, please list: _____

Have you taken any medication /drugs during the past 2 years? Yes

List any medication you are taking and the correlating diagnosis:

Please circle the ones you are allergic to.

Aspirin

Local Anesthetic

Penicillin

Sulfa

Iodine

Codeine

Latex

Barbiturates (sleeping pills)

Other

I understand the above information is necessary to provide me with dental care in a safe efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify Concord Dental Arts of any change in my health or medications.

Patient/Guardian Signature _____ Date _____

Spouse or Responsible Party Information

The following is for: the patient's spouse the person responsible for payment

Name: _____
 Male Female Married Single Child Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____
Street Apartment #
City State Zip Code

Employment Information

Employer Name: _____ Occupation: _____

Address: _____
Street City State Zi

Insurance Information

Name of Insured: _____ Is insured a patient? Yes No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: Self Spouse Child Other _____

Insurance Plan Name and Address: _____

Secondary

Name of Insured: _____ Is insured a patient? Yes No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: Self Spouse Child Other _____

Insurance Plan Name and Address: _____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

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 as 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 be instituted hereunder.

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

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

Signature of patient, parent or guardian Date: _____ Relationship to Patient: _____

Signature of the doctor Date: _____

Concord Dental Arts

Financial Policy

In our continued commitment to provide the highest quality of dental care available to all our patients and to have those services comfortably affordable, we are pleased to offer these options for payments:

- (1) A 5% discount for the total fee if paid in full at the time of treatment.
- (2) Visa, MasterCard, American Express
- (3) A monthly payment plan based upon credit approval. No courtesy discount can be applied.

We will as a courtesy, process your insurance benefits in our office.

The patient is fully responsible for the total payment of all procedures performed in this office. All services are due to be paid in full as services are provided, regardless of whether or not insurance benefits have been received. One and a half percent (1.5%) per month interest will be charged on account balances 60 days from treatment date.

For appointments of 2 hours in duration or longer, a non refundable deposit will be required in order to reserve the appointment. This deposit will be applied to the total charge of the services rendered.

A minimum of 48 hours is required for the cancellation of any appointment. For broken appointments or cancelled appointments that are not made within 48 hours, the deposit will not be applied to services, and an additional deposit may be required in order to reschedule.

For broken appointments or cancelled appointments of normal duration that are not made a minimum of 48 hours in advance, a \$50.00 cancellation fee will be charged.

We are here to assist you in any way possible. Please make your questions and concerns know to our team. Our goal is to ensure that you have an outstanding experience at Concord Dental Arts.

Concord Dental Arts offers a payment plan through care credit GE financial company. We can pre-approve you for this payment option if given the authorization. Please check yes to authorize Concord Dental Arts to get you pre-approved for our no interest plan. Please check no if you are not interested. YES NO

Thank you. The entire team at Concord Dental Arts

I have read and understood the above conditions and agree to their content

Signature _____ Date _____