CONCEPT DENTISTRY

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your dental health. We promise to do our best to provide you with the finest care available.

PLEASE FILL OUT **BOTH SIDES** OF THE REGISTRATION FORM

PATIENT INFORMATION

Patient's Full Name:____ Preferred name, *if any*:_________________

Address:____ City:____________________ State:_____ Zip:_____________

Telephone: *Home* ( ) _____ - _______ *Work* ( ) _____ - _______ *Cell* ( ) _____ - _______

Sex: Male Female Date of birth: ___________________ S.S.#: _____ - ____ - _________

Marital Status:______________________ Email address: ____

Do you have dental insurance? Yes No Person responsible for account: ____

Primary Physician's Name:____ Phone:______________________________

I would like to receive correspondences via (circle all that apply): Phone Email Text Mail

IF THE PATIENT IS A MINOR, PLEASE TELL US ABOUT YOU, THE PARENT/GUARDIAN:

Your Name:____ Relationship to Patient:___________________

Your Address:_______________________________________ City:___________________ State:_____ Zip:___________

Your phone number: *Home* ( ) _____ - _______ *Work* ( ) _____ - _______ *Cell* ( ) _____ - _______

Your S.S. #: _____ - ____ - _________ Your Date of birth: ____________________

<u>If a patient is under the age of 18 years old, he/she must be accompanied by a parent or guardian during the entire appointment. This applies to all appointments. Only a parent or guardian can sign an updated medical history or consent form for a minor patient.</u>

How did you hear about us? ____

EMERGENCY CONTACT INFORMATION
(PLEASE SPECIFY SOMEONE THAT DOES NOT LIVE IN YOUR HOUSEHOLD):

Name: _________________________________ Phone: ______________________Relation to Patient: _______________

EMPLOYER INFORMATION

Employer: ____ Phone: ________________________

Address: ____City: _______________________ State:____ Zip: ____________

INSURANCE INFORMATION

Policy Holder's Name: ____________________ Relationship to Patient: ____________

Name of Insurance Company: ____________________ Phone: ____________

Employer: ____________________ Phone: ____________

Subscriber ID: ____________ Date of Birth: ________ Group number/effective date: ____________

DO YOU HAVE ANY ADDITIONAL INSURANCE? Yes No If Yes, complete the following:

Policy Holder's Name: ____________________ Relationship to Patient: ____________

Name of Insurance Company: ____________________ Phone: ____________

Employer: ____________________ Phone: ____________

Subscriber ID: ____________ Date of Birth: ________ Group number/effective date: ____________

DENTAL HISTORY INFORMATION

Previous Dentist: ____________ Date of Last Dental Visit: ________ Reason for Last Visit: ____________

What is your immediate concern? ________________________________

CIRCLE YOUR RESPONSES:

1. Have you had an unfavorable dental experience?.......... Yes No
2. Have you had complications from past dental treatment?.......... Yes No
3. Have you ever had trouble getting numb or had any reactions to local anesthetics?.......... Yes No
4. Is there anything about the appearance of your teeth that you would like to change?.......... Yes No
   If yes, please explain: ________________________
5. Have you been disappointed with the appearance of previous dental work?.......... Yes No
6. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping).......... Yes No
7. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits?.......... Yes No
   If yes, please explain: ________________________
8. Do you wear or have you ever worn a bite appliance?.......... Yes No
9. Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth?.......... Yes No
10. Do your gums bleed when flossing or brushing?.......... Yes No
11. Have you ever been treated for gum disease or been told you have lost bone around your teeth?.......... Yes No
12. Do you get food caught in between any teeth? .... Yes No
13. Have you ever noticed an unpleasant taste or odor in your mouth?.......... Yes No

FOR MINOR PATIENTS: (Under the age of 18 years old):

1. Has he/she had any unhappy dental experiences?.......... Yes No
2. Has he/she had any injuries to mouth, teeth or head?.......... Yes No
   If yes, please explain: ________________________
3. Does he/she have any mouth habits – nail biting, chewing on items or mouth breathing?.......... Yes No
4. Does he/she suck his/her thumb, fingers, or pacifier?.......... Yes No
5. Has he/she worn any orthodontic appliances?.......... Yes No
6. How often does he/she brush? ________________ Do you assist with brushing? Yes No

PERMISSION FOR THE TREATMENT & RELEASE OF HEALTH INFORMATION

This is to certify that I, the undersigned, consent to the performing of the dental and oral surgery procedures agreed to be necessary or advisable, including the use of local anesthesia as indicated. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to any child or me during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all service rendered on my behalf or my dependents.

Patient's signature (or parent/guardian if minor): ________________________ Date: ____________