NEW CONCEPTS DENTAL GROUP

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 any questions we will be glad to help you. We look forward to working with you in maintaining your dental health.

Patient Information

Name:		Soc. Sec #
Date:	Home Phone:	Cell Phone:
Street Address:		
City:	State:	Zip:
Sex:	Email:	Birth Date:
☐ Single ☐ Married ☐ Separated ☐ Divorced		
Business Address:		Business Phone:
How did you hear about our office?		
In case of emergency, who should we contact?		Phone:

Primary Insurance

Person responsible for account:		
Relation to Patient:	Birth Date:	Soc. Sec #
Address (if different from patient):		Phone:
City:	State:	Zip:
Subscriber employeed by:		Birth Date:
Insurance Company:		
Contract #:	Group #:	Subscriber #:
Name of other dependents covered by this plan:		

Additional Insurance

Is patient covered by additional insurnace?		
Subscriber Name:	Relation to Patient:	Birth Date:
Address (if different from patient):		Phone:
City:	State:	Zip:
Subscriber employed by:		Birth Date:
Insurance Company:		
Contract #:	Group #:	Subscriber #:
Name of other dependents covered by this plan:		

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Dental History

Reason for today's visit:		Date of last visit:
Former Dentist:		Date of last dental X-rays:
Address:		
City:	State:	Zip:

Check if you have had any problems with any of the following:

Bad Breath	Grinding teeth	Sensitivity to heat
Bleeding Gums	Loose or broken teeth	Sensitivity to sweets
Clicking or popping jaw	Periodontal treatment	Sensitivity when biting
Food collects between teeth	Sensitivity to cold	Sores or growths in mouth

Medical History

Physician's name:	Date of last visit:
Have you had any serious illnesses or operations:	
If yes, please describe:	
(Women) are you pregnant?	Nursing:

Check if you have had any of the following:

Anemia	Cortisone treatments	Hepatitis	High blood pressure	Chemical dependence
Arthritis	Persistent cough	HIV/AIDS	Artificial heart valve	Respitory disease
Skin Rash	Cough up blood	Asthma	Artificial joint	Shortness of breath
Diabetes	Jaw pain	Epilepsy	Kidney disease	Hemophilia
Stroke	Swelling of feet/ankles	Faiting	Back problems	Rhematic fever
Liver Disease	Thyroid problems	Cancer	Blood disease	Circulatory problems
Headaches	Mitral valve prolapse	Glaucoma	Tobacco habit	Heart murmur
Pacemaker	Tonsillitis	Ulcer	Turberculosis	Radiatation treatment

Authorization

I authorize my insurance company to pay the dental group all insurance benefits otherwise payable to me for services rendered. I authorize the use of my signature on all insurance submissions. I authorize the dentist to release all information necessary to secure the payment of benefits. I understand I am financially responsible for all charges whether or not paid by insurance.

Signature ______________________________ Date: ____________________