CONCEPTS DENTISTRY

Welcome to Concepts Dentistry! We are so happy that you have chosen us for your dental care.

Here at Concepts, you, your smile, and your health are our passion. We strive to provide you with the highest quality dental care in warm, calm environment. We hope you will always feel comfortable and cared for here.

We encourage you to contact us if you have any questions regarding your care. We are looking forward to working with you and taking care of all of your dental needs!

This packet includes:

- Patient Registration
- Medical History
- Dental History
- Financial Policy
- HIPPA Policy

Please fill out the included paperwork and bring it with you to your first appointment!

3007 N Delta Hwy Ste. 203 Eugene, OR 97408   P: 541.987.1134

PATIENT REGISTRATION

PATIENT INFORMATION:

First Name:______________________________________Last Name_____________________________Middle Initial: _____

Address:____City:____________State:________Zip Code: ________

Home Phone:______________________Work Phone:____________________Ext.:____ Cell Phone: _______________________

Birthdate:_____________Email:_______________________________________ Sex Assigned at Birth: ☐ Male ☐ Female

Preferred Pronouns: _______________

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Who may we thank for referring you? ☐Family/Friend: _______________________ ☐ Insurance ☐Google ☐ Facebook

☐ Other: _______________________

Employer:____Occupation: ____

Previous Dentist & Phone Number: ____

Emergency Contact & Phone Number: ____

RESPONSIBLE PARTY: Patient is: ☐ Responsible Party

First Name:____________________________Last Name:___________________________________Middle Initial: ____________

Relation to patient: ____

Address:____City:State:_____________Zip Code: ________________

Home Phone:______________________Work Phone:____________________Ext: ____ Cell Phone: _____________________

Email:_____________________________ Employer:_________________________________Occupation: _____________________

In Office Signatures:

I have read and understand the Notice of Privacy Practices and Authorization (HIPPA).

Signature:____ Date: _____________________

Relationship to patient: ____

I give my consent to Concepts Dentistry to notify/contact me via unencrypted email or text which may include personalhealth information. (ex: appointment reminders, notifications)

Signature:____ Date: _____________________

Relationship to patient: ____

CONCEPTS DENTISTRY

MEDICAL HISTORY

Patient Name: ______________________________ Birthdate: ______________

Although dental personnel primarily treat the area in and around your mouth, your mouth is a 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.

If you answer yes to the following questions, please share more.	YES	NO
Are you under a physician's care now? ______	☐	☐
Have you ever been hospitalized or had a major operation? ______	☐	☐
Have you ever had a serious head or neck injury? ______	☐	☐
Are you taking any medications, pills, or drugs? ______	☐	☐
If yes, please provide a MED LIST: ______	☐	☐
Do you take, or have you taken Phen-Fen or Redux? ______	☐	☐
Have you ever taken Fosamax, Boniva, Actonel, or any other medication containing bisphosphonates? ______	☐	☐
Are you on a special diet? ______	☐	☐
Do you use tobacco, vapes, marijuana (Please circle which one(s)? If so, how often? ______	☐	☐
Do you use controlled substances? If so, what and how often? ______	☐	☐

* Women, are you: (circle all that apply) Pregnant Trying to get pregnant Taking oral contraceptives Nursing

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal
☐ Latex ☐ Sulfa Drugs ☐ Barbiturates ☐ Pain Meds ☐ Sedatives ☐ Iodine Other: ______

Please check all that apply currently or that you've had in the past. Please write about when you experienced these things.

Condition	YES	NO
AIDS/HIV Positive	☐	☐
Alzheimer's Disease	☐	☐
Anaphylaxis	☐	☐
Anemia	☐	☐
Angina	☐	☐
Arthritis/Gout	☐	☐
Artificial Heart Valve	☐	☐
Artificial Joint	☐	☐
Asthma	☐	☐
Atrial Fibrillation	☐	☐
Blood Disease	☐	☐
Blood Transfusion	☐	☐
Breathing Problem	☐	☐
Bruise Easily	☐	☐
Cancer	☐	☐
Chemotherapy	☐	☐
Chemical Dependency	☐	☐
Chest Pains	☐	☐
Cold Sores/Fever Blisters	☐	☐
Congenital Heart Disorder	☐	☐
Convulsions	☐	☐
Cortisone Medicine	☐	☐
C-PAP Machine	☐	☐
Diabetes	☐	☐
Dementia	☐	☐
Drug Addiction	☐	☐
Easily Winded	☐	☐
Emphysema	☐	☐
Epilepsy or Seizures	☐	☐
Excessive Bleeding	☐	☐
Excessive Thirst	☐	☐
Fainting Spells/Dizziness	☐	☐
Frequent Cough	☐	☐
Frequent Diarrhea	☐	☐
Frequent Headaches	☐	☐
Genital Herpes	☐	☐
GERD	☐	☐
Glaucoma	☐	☐
Hay Fever	☐	☐
Heart Attack/Failure	☐	☐
Heart Murmur	☐	☐
Heart Pacemaker	☐	☐
Heart Trouble/Disease	☐	☐
Heart Surgery	☐	☐
Hemophilia	☐	☐
HepA/Jaundice	☐	☐
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	☐	☐
MRSA	☐	☐
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/Crohn's	☐	☐
Stroke	☐	☐
Swelling of Limbs	☐	☐
Thyroid Disease	☐	☐
Tonsillitis	☐	☐
Tuberculosis	☐	☐
Tumors or Growths	☐	☐
Ulcers	☐	☐
Venereal Disease	☐	☐
Yellow Jaundice	☐	☐
Sleep Apnea	☐	☐

Any other medical condition or illness not listed above? ______

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 the patient's) health. It is my responsibility to inform the dental office of any changes in my medical status.

Signature of Patient, Parent, or Guardian ______ Date: ______

PLEASE TURN PAGE →

DENTAL HISTORY

Name: ____

How would you rate the condition of your mouth? Excellent Good Fair Poor

Previous Dentist:____________________ How long have you been a patient? ____________________

Date of most recent dental exam:__________ Date of most recent x-rays:____________________

Date of most recent treatment (other than cleaning): ____________________

I routinely see the dentist every: 3 months 4 months 6 months 12 months not routinely

Do you take a pre-medication before dental appointment? ☐ No ☐ Yes If yes, what? ____________________

What is your immediate concern? ____________________

Please answer yes or no to the following:

YES NO

Personal History

1. Are you fearful of dental treatment? How fearful on a scale of 1 (least) to 10 (most)? __________ ☐ ☐
2. Have you had complications from past dental treatment? __________ ☐ ☐
3. Have you ever had trouble getting numb or had any reactions to local anesthetic? __________ ☐ ☐
4. Did you ever have braces, orthodontic treatment or have your bite adjusted? __________ ☐ ☐
5. Have you had any teeth removed? __________ ☐ ☐

Smile Characteristics

1. Is there anything about the appearance of your teeth you would like to change? __________ ☐ ☐
2. Have you ever whitened (bleached) your teeth? __________ ☐ ☐
3. Have you felt uncomfortable or self-conscious about the appearance of your teeth? __________ ☐ ☐
4. Have you been disappointed with the appearance of previous dental work? __________ ☐ ☐

Bite & Jaw Joint

1. Does your jaw pop, click, lock, open, limited opening, any pain? __________ ☐ ☐
2. Do you/would you have any problems chewing gum, or firm foods? __________ ☐ ☐
3. Do you chew ice, bite your nails, use your teeth to hold objects or have any other oral habits? __________ ☐ ☐
4. Do you clench or grind your teeth during the day or at night during your sleep? __________ ☐ ☐
5. Do you have any problems with sleep or wake up with an awareness of your teeth? __________ ☐ ☐
6. Do you wear or have you ever worn a bite appliance? __________ ☐ ☐

Tooth Structure

1. Does the amount of saliva in your mouth seem too little or do you have any difficulty swallowing any food? __________ ☐ ☐
2. Do you feel or notice any holes (i.e., pitting, craters) on the biting surface of your teeth? __________ ☐ ☐
3. Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth? __________ ☐ ☐

Biology

1. Do your gums bleed or are they painful when brushing or flossing? __________ ☐ ☐
2. Have you ever been treated for gum disease or been told you have lost bone around your teeth? __________ ☐ ☐
3. Are you noticing ever an unpleasant odor in your mouth? __________ ☐ ☐
4. Is there anyone with a history of periodontal disease in your family? __________ ☐ ☐

Where is your preferred pharmacy? Address: ____________________

Phone number: ____________________

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FINANCIAL POLICY

Thank you for choosing our dental practice. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

We accept these forms of payment:

Cash - Check - Master Card - Visa - Discover - American Express

We offer a 10% courtesy adjustment to patients who do ***NOT*** have insurance and pay for their treatment with cash/check AT THE TIME OF SERVICE

Please Note:

We charge 18% interest on all past due accounts. Also please note: if your account has to be assigned to a collection agency we will charge a fee of 35% of the balance at the time of assignment.

For patients with dental insurance, we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment. However, if we do not receive payment from you insurance carrier within 60 days, you will be responsible for payment of your treatment fees and collection of your benefits directly for your insurance carrier.

A fee of $70 is charged for patients who miss or cancel more than 2 times in a calendar year without a 24-hour notice.

This is a $50 charge for returned checks.

Please don't hesitate to ask if you have any questions regarding this financial agreement. We are committed to providing you with the ultimate experience in dental care but need your financial commitment as well.

____

Print name of patient or responsible party **Date**

____

Signature of patient or responsible party **Date**

PLEASE TURN PAGE →

ACKNOWLEDGEMENT OF PRIVACY PRACTICE

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA). I understand that this information can and will be used to:

- Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers for my health care services.
- Conduct normal health care operations such as quality assessment and improvement activities.

I have been informed of my dental provider's Notice of Privacy Practices containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such Notice of Privacy Practices. I understand that my dental provider has the right to change the Notice of Privacy Practices and that I may contact this office to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Please list the individuals below who have our permission to share your health information:

Name	Relationship to Patient

Patient Name: ____ Date: ____________________

Signature: ____

Relationship to Patient: ____