Patient # _____ Date: _____

Shoreham Family Dental

WELCOME

To help us meet all your healthcare needs, please fill out this form completely. If you have any questions about this form, please ask us and we will be happy to help.

Patient Information (Confidential)

Name _____ Home Phone _____

SS# _____ Birthdate _____

Address _____ City/State/Zip _____

Email _____ Cell Phone _____

If Student, Name of School/College & Address _____ Full Time ___ Part Time ___

Employer & Address _____ Work Phone _____

Minor _____ Single _____ Married _____ Separated _____ Divorced _____ Widowed _____

Spouse or Parent/Guardian's Name, Employer & Phone _____

Person to Contact in Case of Emergency _____ Phone Number _____

Where did you hear about us? _____

Responsible Party

Name of Person Responsible for this Account _____ Relationship to Patient _____

Address _____ City/State/Zip _____

Email _____ Home Phone _____

Birthdate _____ Employer & Address _____

Work Phone _____ Is This Person Currently a Patient in our Office? _____

Which payment method do you prefer? Cash _____ Check _____ VISA/MasterCard _____

Insurance Information

Name of Insured _____ Relationship to Patient _____ Birthdate _____ SS# _____

Name of Employer & Address _____ Work Phone _____

Insurance Company _____ Group # _____ Policy ID# _____

Insurance Company Address _____

How Much Is Your Deductible? _____ How Much Have You Used? _____ Maximum Annual Benefit _____

Do You Have Any Additional Insurance? Yes _____ No _____ If Yes, Please Complete The Section Below.

Name of Insured _____ Relationship to Patient _____ Birthdate _____ SS# _____

Name of Employer & Address _____ Work Phone _____

Insurance Company _____ Group # _____ Policy ID# _____

Insurance Company Address _____

How Much Is Your Deductible? _____ How Much Have You Used? _____ Maximum Annual Benefit _____

Patient Medical History

Physician _____ **Office Phone** _____ **Date of Last Exam** _____

1. Are you under medical treatment now? Yes _____ No _____ If yes, please explain
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? Yes _____ No _____
   If yes, please explain _____
3. Are you currently taking any medication(s) including non-prescription medicine? Yes _____ No _____
   If yes, please list all of them _____
4. Do you use any tobacco products? Yes _____ No _____
5. Are you allergic to or have you had any reactions to the following?

Local Anesthetics (ex. Novocain)	Yes _____	No _____
Penicillin or any other antibiotics	Yes _____	No _____
Sulfa Drugs	Yes _____	No _____
Barbiturates	Yes _____	No _____
Sedatives	Yes _____	No _____
Iodine	Yes _____	No _____
Aspirin	Yes _____	No _____
Any Metals (ex. nickel, mercury, etc.)	Yes _____	No _____
Latex Rubber	Yes _____	No _____
Other _____		

6. Do you use controlled substances? Yes _____ No _____
7. Are you taking any blood thinners? Yes _____ No _____
8. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)? Yes ___ No _____

Women Only:

1. Are you pregnant or do you think you might be?
   Yes _____ No _____
2. Are you nursing? Yes _____ No _____
3. Are you taking oral contraceptives? Yes _____ No _____

Do you have or have you had any of the following?

	Y	N		Y	N		Y	N
Mitral Valve Prolapse	☐	☐	Arthritis	☐	☐	Liver Disease	☐	☐
Heart Murmur	☐	☐	Hepatitis	☐	☐	Kidney Disease	☐	☐
Heart Trouble	☐	☐	Emphysema	☐	☐	Diabetes	☐	☐
Heart Attack	☐	☐	Asthma	☐	☐	Thyroid Problems	☐	☐
Heart Disease	☐	☐	Respiratory Problems	☐	☐	Fainting/Seizures	☐	☐
Rheumatic Fever	☐	☐	Cancer	☐	☐	Epilepsy / Convulsions	☐	☐
Angina	☐	☐	Leukemia	☐	☐	Tuberculosis	☐	☐
Stroke	☐	☐	Chemotherapy	☐	☐	Stomach Problems / Ulcers	☐	☐
Cardiac Pacemaker	☐	☐	Radiation Therapy	☐	☐	Glaucoma	☐	☐
Chest Pains	☐	☐	Autoimmune Disease	☐	☐	Anemia	☐	☐
High/Low Blood Pressure	☐	☐	AIDS or HIV Infection	☐	☐	Recent Weight Loss	☐	☐
Joint Replacement or Implant	☐	☐	Sexually Transmitted Disease	☐	☐	Other	☐	☐

Patient Dental History

Previous Dentist _____ **Location/Phone Number** _____

1. Do your gums bleed while brushing/flossing? Yes No
2. Are your teeth sensitive to hot/cold liquids/foods? Yes No
3. Are your teeth sensitive to sweet/sour liquids/foods? Yes No
4. Do you feel pain in any of your teeth? Yes No
5. Do you have any sores or lumps in or near your mouth? Yes No
6. Have you had any head, neck or jaw injuries? Yes No
7. Have you ever experienced any of the following problems in your jaw?
   Clicking Yes No
   Pain/Difficulty in opening or closing your mouth? Yes No
8. Do you have frequent headaches? Yes No
9. Do you clench or grind your teeth? Yes No
10. Do you bite your lips or cheeks frequently? Yes No
11. Have you had any difficult extractions in the past? Yes No
12. Any prolonged bleeding following extractions? Yes No
13. Have you had any orthodontic treatment? Yes No
14. Do you wear dentures or partials? Yes No
    If yes, date of placement _____
15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums? Yes No
16. Do you like your smile? Yes No

Authorization & Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child 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 dentists 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 services rendered on my behalf or my dependent. I understand an 18% interest charge may be applied to my account for balances over 90 days.

Signature of Patient (parent/guardian if minor) _____