PATIENT INFORMATION (Confidential)

Today's Date_____

Name_____ Birth date_____ Sex___ Marital Status_____ SS #_____
Address_____ City_____ State_____ Zip code_____
Home Phone_____ Work_____ Cellular_____
Employer_____ Address_____
City/State_____ Zip code_____ email: _____
Spouse or Parent's Name_____ Employer_____ Work Phone_____
If Student, Name of School/College_____

INSURANCE INFORMATION

Name of Insured_____ Phone_____
Relationship to Patient_____ Birth date_____ Soc. Sec. #_____
Employer_____ Date of Employment_____ Work Phone_____
Insurance Company_____ Group#_____ ID#_____
Ins. Co. Address_____ City/State_____ Zip code_____

PATIENT MEDICAL HISTORY

	YES	NO
1. Are you under medical treatment now?	__	__
2. Have you ever been hospitalized for any serious illness within the last 5 years? If yes, please explain_____	__	__
3. Have you ever taken Phen-Fen/ Redux?	__	__
4. Do you use tobacco?	__	__
5. Do you use controlled substances?	__	__
6. Are you wearing contact lenses?	__	__
7. Are you taking any medications? If yes, what?_____	__	__

8. Are you allergic to or have you had any reactions to:

	YES	NO
Allergic to Antibiotics	__	__?
Local Anesthetics (Novocaine)	__	__
Sulfa Drugs	__	__
Barbiturates	__	__
Iodine	__	__
Aspirin	__	__
Any Metals (e.g. nickel, mercury etc...)	__	__
Latex Rubber	__	__
Sedatives	__	__
Other?_____		

9... Women Only:

Are you pregnant or think you may be pregnant?	__	__
Are you taking oral contraceptives?	__	__
Are you nursing?	__	__

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

	YES	NO
High Blood Pressure	__	__
Heart Attack	__	__
Rheumatic Fever	__	__
Swollen Ankles	__	__
Fainting/Seizures	__	__
Asthma	__	__
Low Blood Pressure	__	__
Epilepsy/Convulsions	__	__
Leukemia	__	__
Diabetes	__	__
Kidney Diseases	__	__
AIDS or HIV Infection	__	__
Thyroid Problem	__	__

	YES	NO
Heart Disease	__	__
Cardiac Pacemaker	__	__
Heart Murmur	__	__
Angina	__	__
Frequently Tired	__	__
Anemia	__	__
Emphysema	__	__
Cancer	__	__
Arthritis	__	__
Joint Replacement or Implant	__	__
Hepatitis/Jaundice	__	__
Sexually Transmitted Disease	__	__
Stomach Troubles/Ulcers	__	__

	YES	NO
Chest Pains	__	__
Easily Winded	__	__
Stroke	__	__
Hay Fever/Allergies	__	__
Tuberculosis	__	__
Radiation Therapy	__	__
Glaucoma	__	__
Recent Weight Loss	__	__
Liver Disease	__	__
Heart Trouble	__	__
Respiratory Problems	__	__
Mitral Valve Prolapse	__	__
Other_____	__	__

I _____, have chosen to allow South Shore Dentistry to file my insurance and accept full responsibility for this account and all dentistry performed upon my family in this dental office. I understand it is my responsibility to be aware of what type of dental plan I have and notify the office of any changes on insurance coverage. I also understand that this office cannot guarantee that my insurance company will cover all services rendered and it is only an **estimate of benefits.** I also understand that any outstanding balance left on my account after insurance has made payments will become my responsibility.

Patient Signature : _____ Date:_____

Staff Signature:_____ Date:_____

CANCELLATION POLICY: A 24 hour cancellation notice would be greatly appreciated. Multiple cancellations may result in an office fee. Thank you your consideration in this matter.