



South Shore Dentistry  
Michael E. Jaeger, DDS  
Robert McClary, DDS  
Chancellor Corporate Center  
12012 So. Shore Blvd. Suite 101  
Wellington, FL 33414

## New Patient Intake Form

Thank you for selecting us for your dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely. If you have any questions or need assistance, please ask us. We will be happy to help.

Hover form fields for instructions.

Today's date \_\_\_\_\_

### Patient Information

\_\_\_\_\_  
Name \_\_\_\_\_ Date of birth \_\_\_\_\_ Gender \_\_\_\_\_ Marital status \_\_\_\_\_ SSN \_\_\_\_\_  
Email \_\_\_\_\_  Employed  Unemployed  Full-time student  
Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_  
Cell phone \_\_\_\_\_ Home phone \_\_\_\_\_ Work phone \_\_\_\_\_  
Employer or school name \_\_\_\_\_  
Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_  
\_\_\_\_\_  
Emergency contact name \_\_\_\_\_ Phone \_\_\_\_\_ Who referred you? \_\_\_\_\_

### Responsible Party

\_\_\_\_\_  
Name \_\_\_\_\_ Home/cell phone \_\_\_\_\_ Date of birth \_\_\_\_\_ Relationship to patient \_\_\_\_\_  
\_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_  
\_\_\_\_\_  
Employer name \_\_\_\_\_ Employment date \_\_\_\_\_ Work phone \_\_\_\_\_ DL number \_\_\_\_\_  
Is this person a current patient in our office?  Yes  No

## Insurance Information

### Primary Insurance Policy

Subscriber name \_\_\_\_\_ SSN \_\_\_\_\_ Date of birth \_\_\_\_\_ Relationship to patient \_\_\_\_\_  
Insurance company \_\_\_\_\_ Contract number \_\_\_\_\_ Group number \_\_\_\_\_  
Deductible \_\_\_\_\_ Yearly maximum \_\_\_\_\_ How much has been used? \_\_\_\_\_

### Secondary Insurance Policy

Subscriber name \_\_\_\_\_ SSN \_\_\_\_\_ Date of birth \_\_\_\_\_ Relationship to patient \_\_\_\_\_  
Insurance company \_\_\_\_\_ Contract number \_\_\_\_\_ Group number \_\_\_\_\_  
Deductible \_\_\_\_\_ Yearly maximum \_\_\_\_\_ How much has been used? \_\_\_\_\_

## Methods of Payment

FOR YOUR CONVENIENCE WE OFFER THE FOLLOWING METHODS OF PAYMENT: Cash, Personal Check, Credit Cards: Visa, Master Card or Discover Payment is due in full at each appointment. Our office accepts most insurance plans. I understand that I am responsible for payment of services rendered and for paying any co-payment and deductibles that my insurance does not cover. I am also aware that the fee collected is just an estimate of what I am responsible for and that any balance the insurance company does not cover, I am responsible for.

## Cancellation Policy

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

## Patient Medical History

Physician name \_\_\_\_\_ Office phone \_\_\_\_\_ Last exam \_\_\_\_\_

Are you currently under medical treatment?  Yes  No

Have you been hospitalized for any serious illnesses in the last 5 years?  Yes  No

If yes, explain \_\_\_\_\_

Have you ever taken Phen-Fen/Redux?  Yes  No

Do you use tobacco?  Yes  No

Do you use controlled substances?  Yes  No

Are you wearing contact lenses?  Yes  No

Are you taking any medications?  Yes  No

If yes, list \_\_\_\_\_

## Patient Medical History (cont'd)

Are you allergic to or have you had reactions to any of the following?

Antibiotics  Yes  No

Aspirin  Yes  No

Local anesthetics (Novocaine)  Yes  No

Metals  Yes  No

Sulfa drugs  Yes  No

Latex  Yes  No

Barbiturates  Yes  No

Sedatives  Yes  No

Iodine  Yes  No

Other (list) \_\_\_\_\_

### Women only:

Are you pregnant or think you may be pregnant?  Yes  No

Are you taking oral contraceptives?  Yes  No

Are you nursing?  Yes  No

Select if you have ever had any of the following conditions.

High blood pressure

Heart disease

Chest pains

Heart attack

Cardiac pacemaker

Easily winded

Rheumatic fever

Heart murmur

Rheumatic Stroke

Swollen ankles

Angina

Hay fever/allergies

Fainting/seizures

Frequently tired

Tuberculosis

Asthma

Anemia

Radiation therapy

Low blood pressure

Emphysema

Glaucoma

Epilepsy/convulsions

Cancer

Unintentional weight loss

Leukemia

Arthritis

Respiratory problems

Diabetes

Joint replacement

Liver disease

Kidney disease

Hepatitis/jaundice

Mitral valve prolapse

HIV/AIDS

Sexually transmitted disease

Other

Thyroid problems

Stomach problems/ulcers

\_\_\_\_\_

## Patient Dental History

Previous dentist \_\_\_\_\_ Location \_\_\_\_\_ Last exam \_\_\_\_\_

Do your gums bleed while brushing or flossing?  Yes  No

Are your teeth sensitive to hot or cold liquids/foods?  Yes  No

Are your teeth sensitive to sweet or sour liquids/foods?  Yes  No

Do you feel pain in any of your teeth?  Yes  No

Do you have any sores or lumps in or near your mouth?  Yes  No

Have you had any head, neck, or jaw injuries?  Yes  No

## Patient Dental History (cont'd)

Have you ever experienced any of the following problems in your jaw?

Clicking?  Yes  No

Pain (joint, ear, side of face)?  Yes  No

Difficulty in opening or closing?  Yes  No

Difficulty in chewing?  Yes  No

Do you clench or grind your teeth?  Yes  No

Do you bite your lips or cheeks frequently?  Yes  No

Have you ever had any difficult extractions?  Yes  No

Have you ever had any prolonged bleeding following extractions?  Yes  No

Have you had any orthodontic treatment?  Yes  No

Have you ever received oral hygiene instructions regarding the care of your teeth and gums?  Yes  No

Are you satisfied with the appearance of your teeth?  Yes  No

If no, what would you change? \_\_\_\_\_

## Authorization and 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 rendered to me or my child during the period of such dental care to third party payers 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 services rendered on my behalf or my dependents. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment, with my informed consent.

\_\_\_\_\_  
Patient signature and date

Dentist comments