South Shore Dentistry
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Existing Patient Form

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 _____

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? _____

Patient Medical History

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 _____

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

Antibiotics ◯ Yes ◯ No

Local anesthetics (Novocaine) ◯ Yes ◯ No

Sulfa drugs ◯ Yes ◯ No

Barbiturates ◯ Yes ◯ No

Iodine ◯ Yes ◯ No

Aspirin ◯ Yes ◯ No

Metals ◯ Yes ◯ No

Latex ◯ Yes ◯ No

Sedatives ◯ 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 attack
- ☐ Rheumatic fever
- ☐ Swollen ankles
- ☐ Fainting/seizures
- ☐ Asthma
- ☐ Low blood pressure
- ☐ Epilepsy/convulsions
- ☐ Leukemia
- ☐ Diabetes
- ☐ Kidney disease
- ☐ HIV/AIDS
- ☐ Thyroid problems
- ☐ Heart disease
- ☐ Cardiac pacemaker
- ☐ Heart murmur
- ☐ Angina
- ☐ Frequently tired
- ☐ Anemia
- ☐ Emphysema
- ☐ Cancer
- ☐ Arthritis
- ☐ Joint replacement
- ☐ Hepatitis/jaundice
- ☐ Sexually transmitted disease
- ☐ Stomach problems/ulcers
- ☐ Chest pains
- ☐ Easily winded
- ☐ Rheumatic Stroke
- ☐ Hay fever/allergies
- ☐ Tuberculosis
- ☐ Radiation therapy
- ☐ Glaucoma
- ☐ Unintentional weight loss
- ☐ Respiratory problems
- ☐ Liver disease
- ☐ Mitral valve prolapse
- ☐ Other

_____

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.

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 signature and date

Staff signature and date

Submit by Email