Shore Dental Arts, P.A.

Family, Cosmetic & Implant Dentistry

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions, we will be glad to help you. We look forward to working with you in maintaining your dental health.

Date: _____

Cell Phone: _____
E-Mail: _____
Home Phone: _____
Work Phone: _____

Patient Information

Name: _____ SS#: _____
Last First Initial

Address: _____
City: _____ State: _____ Zip:_____
Sex: □M □F Age_____ Birth Date_____/_____/_____
Marital Status: □Single □Married □Widowed □Separated □Divorced

Patient Employed By: _____ Occupation: _____
Business Address: _____ Business Phone: _____

Emergency Contact: _____ Phone: _____

*Who may we thank for referring you to Shore Dental Arts? _____

Primary Dental Insurance

Person Responsible for Account: _____
Last First Initial

Relationship to Patient: _____ Birth Date: _____/_____/_____ SS#: _____

Address: (*if different from patient's*) _____

City: _____ State: _____ Zip: _____

Responsible Party Employed By: _____ Occupation: _____

Business Address: _____ Business Phone: _____

Insurance Company: _____ Group #: _____

Subscriber ID #: _____

Other Dependent(s) Covered Under This Plan: _____

Additional Dental Insurance

Is Patient Covered By Additional Insurance? □ No □ Yes

***If yes, please complete the following:**
Person Responsible for Account_____
Last First Initial
Relationship to Patient:_____ Birth Date: _____/_____/_____ SS#:_____

Address: (*if different from patient's*)_____ City:_____

State: _____ Zip: _____

Responsible Party Employed By: _____ Occupation: _____

Business Address: _____ Business Phone: _____

Insurance Company: _____Group #: _____

Subscriber ID #: _____

Other Dependent(s) Covered Under This Plan: _____

Dental History

Reason for Today's Visit: _____

Former Dentist: _____

Address: _____ Phone: _____

Date of Last Dental Care: _____ Date of Last Dental X-Rays: _____

Check if you have had problems with any of the following:

□ Bad Breath	□ Grinding Teeth	□ Sensitivity to Hot
□ Bleeding Gums	□ Loose Teeth or Broken Fillings	□ Sensitivity to Sweets
□ Clicking or Popping Jaw	□ Periodontal Treatment	□ Sensitivity When Biting
□ Food Collection between Teeth	□ Sores/Growths	□ Sensitivity to Cold

How often do you floss? _____ How often do you brush? _____

Medical History

Physician's Name: _____ Phone: _____ Date of Last Visit: _____

Have you ever had any serious illnesses? □ No □ Yes
If yes, please be specific and give approximate dates:
_____
Have you ever had any operations? □ No □ Yes
If yes, please be specific and give approximate dates:
_____

Check if you have had problems with any of the following:

□ Aids □ Cortisone Treatments □ Hepatitis □ Rheumatic Fever
□ Anemia □ Persistent Cough □ High Blood Pressure □ Scarlet Fever
□ Arthritis Rheumatism □ Cough Up Blood □ HIV Positive
□ Shortness of Breath
□ Artificial Heart Valves □ Diabetes □ Jaw Pain □ Skin Rash
□ Artificial Joints □ Epilepsy □ Kidney Disease □ Stroke
□ Asthma □ Fainting □ Liver Disease
□ Swelling of Feet/Ankles
□ Back Problems □ Glaucoma □ Mitral Valve Prolapse □ Thyroid Problems
□ Blood Disease □ Headaches □ Nervous Problems □ Tobacco Habit
□ Cancer □ Heart Murmur □ Pacemaker □ Tonsillitis
□ Chemical Dependency □ Heart Problems □ Psychiatric Care □ Tuberculosis
□ Chemotherapy (*describe*) _____ □ Radiation Treatment □Ulcer
□ Circulatory Problems □ Hemophilia □ Respiratory Disease
□ Venereal Disease

*List All Medications You Are Taking, Including Over the Counter Medication:

_____

_____

_____

*Allergies to Medications:

_____

Authorization

I authorize my insurance company to pay the dentist or dental group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

X_____ Date_____
Signature of Patient or Parent if Minor