South Shore Dentistry
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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

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 ______________________________

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