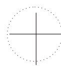
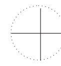

Patient's name ______________________________
LAST FIRST INITIAL

Gender: M F

How do you wish to be addressed? ____________

single married separated divorced

Date of birth ____________ **Today's Date** ____________

If child: guardian's name ______________________________
LAST FIRST INITIAL

Address ______________________________

City ____________ State______ Zip ________

Home phone: ____________

Bus phone: ____________

Cell: ____________

Email address ____________

SSN: ____________

Patient employed by: ____________

Bus address: ____________

Present position: ____________

Spouse/Partner name: ____________

Spouse/Partner employed by: ____________

Bus address: ____________

Bus Phone: ____________ Cell:____________

Other family members in the practice

____

Are you a full time college student? yes no

Name of college ____________

Name and phone number of someone (not living with you) to notify in case of emergency

____

Whom may we thank for this referral?

____

YOUR MEDICAL DOCTOR

Name: ____________

Address or Hospital Name: ____________

City: ____________ State:______ Zip:

Office Phone: ____________

Date of Last Visit and Reason: ____________

____

YOUR PRIOR DENTIST

Name ____________

Address: ____________

City: ____________State:______ Zip: ________

YOUR DENTAL HISTORY

Are you in discomfort now? Yes No

If yes, please describe: ____________

____

Approximate Date of Last Examination: ____________

What was discussed or treated at that time:

____

____

What are your reasons for this visit and your expectations of South Shore Dental Group? ____________

____

____

RELEASE: all information held by this office is considered confidential, and will not be released without prior consent

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.

I authorize the release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

I hereby authorize payment of insurance benefits directly to South Shore Dental Group.

I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services. *I understand that I am financially responsible for payments of all accounts, and accept the responsibility for monitoring insurance payments and plan limitations..* I hereby agree to be responsible for payment of services not paid, in whole or in part by my dental insurance company.

I attest to the accuracy of the information on this page.

PATIENT / GUARDIAN'S SIGNATURE ______________________________ **DATE** ____________

South Shore Dental Group
Patient Registration

South Shore Dental Group Medical History

Last Name_______________**First Name**__________________**MI**_____**Mr/Mrs/Ms/Dr** **Date of Birth** ___/___/___

PCP Name______________________________________

Address____

Phone_____________________Date Last Visit_____________

Please list any prescription and non-prescription medications you are taking.

Medications	Reason for the medication

General Health

1. Are you under care of a physician at this time? Yes No
2. If so, what condition is being treated? _______________

    ____

3. Women: Are you pregnant? Yes No
    Are you taking birth control pills ? Yes No

4. Have you ever had a major illness or surgery? Yes No

    If yes, please explain: ____________________________

5. Do you have any artificial joints or prostheses? Yes No
    Hip Knee Pacemaker Defibrilator
    Other:____

6. Have you ever had treatment for cancer or a tumor or growth? Yes No
    If yes, please explain______________________________

    ____

7. Have you been diagnosed with sleep apnea? Yes No
    If yes, do you use a CPAP machine? Yes No
    If yes, how many nights/week do you use it? ___________

Are you allergic to or have you had a reaction to:
Please check all that apply

local anesthetics	
penicillin or other antibiotics	
sulfa drugs	
barbiturates, sedatives, or sleeping pills	
aspirin, ibuprofin, Tylenol	
codeine, percodan or other narcotic pain killers	
latex	
other	

Do *you have* or *have you had* any of the following diseases or problems?

Problem or disease		
High blood pressure	No	Yes
Heart problems (angina, arteriosclerosis, heart attack)	No	Yes
Heart murmur, mitral valve prolapse, damaged valves, artificial valves	No	Yes
Stroke	No	Yes
High Cholesterol	No	Yes
Swollen ankles	No	Yes
Rheumatic fever	No	Yes
Arthritis	No	Yes
Sinus problems	No	Yes
Diabetes: Type I or II	No	Yes
STD's, AIDS or HIV infection	No	Yes
Thyroid problem	No	Yes
Chest pain on exertion	No	Yes
Stomach ulcer, reflux, IBS, stomach problems	No	Yes
Persistent heartburn	No	Yes
Liver disease, Hepatitis (jaundice), kidney disease	No	Yes
Recent significant weight gain or loss	No	Yes
COPD, emphysema, bronchitis, asthma, persistent cough, breathing problems	No	Yes
Do you use tobacco (smoking, snuff, chew)	No	Yes
Epilepsy, fainting spells or other neurologic problems	No	Yes
Are you taking or have you taken medications for osteoporosis, Paget's Disease, multiple myeloma (Fosamax, Actonel, Zometa, Aredia)	No	Yes
Autoimmune disease (Lupus, others)	No	Yes
Bleeding issues, hemphilia, blood transfusions	No	Yes
Glaucoma	No	Yes
Tuberculosis	No	Yes
TMJ and Sleep Related Problems		
Persistent or chronic headaches	No	Yes
Loud snoring?	No	Yes
Persistent tiredness or fatigue during the day?	No	Yes
Has anyone observed you stop breathing at night?	No	Yes
Frequent morning headaches?	No	Yes
Do you have trouble remembering things or paying attention during the day?	No	Yes

Patient Signature:_________________________Dr. Signature________________________________Date_____________