Shoreland Dental

Patient Information

We are looking forward to having you join our great family of friends and patients. The benefits of a healthy, beautiful smile are immeasurable. Our goal is to allow you to obtain the healthy teeth and attractive smile you want and deserve. Please complete this form so that we can provide you the best care possible.

Name: _____ Date: _____ Gender: M / F

I Like To Be Called: _____ Email: _____

Address: _____
Street City State Zip

Birth Date: _____Telephone:_____/_____/_____
Home Work Cell

Place of Employment: _____ SS#:_____

Dental Insurance

Insurance Carrier: _____ Policy#_____

Employee Name: _____ SS#:_____

Birth Date: _____Employer:_____

Do you have 2nd coverage: Yes / No If yes, Insurance Carrier: _____

Policy #:_____ Employee Name: _____

SS#_____ Birth Date: _____ Employer: _____

PERSON TO CONTACT IN CASE OF EMERGENCY

Outside of immediate family/household

Name: _____ Address: _____Telephone: _____

Referral

Has any member of your family ever been treated in our office: Yes / No
If yes, name of family member: _____
Whom may we thank for referring you to our office: _____

As you may know, your dental insurance does not always cover the cost of treatment. In these instances, you are financially responsible for your treatment. To keep our fees as low as possible, we ask that you pay your fee/co-payment at the time you receive treatment. If you have dental insurance, as a courtesy, we will file your dental claim for you and wait for the estimated insurance payment for 30 days. It becomes the patient's responsibility to cover any amounts or procedures that are not covered by their insurance plan. Checks that are returned to office are subject to a $30.00 returned check fee. Please notify us 24 hours in advanced if you are unable to keep your appointment otherwise you will be charged $25.00 for first cancelled/missed appointment and $50.00 after second and subsequent cancelled/missed appointments.

Signature of Patient or Guardian Date

Medical History

Patient Name:

_____

Who was your previous Dentist? _____

When was your last dental exam? _____

Have you ever had major operation? **Y / N** Describe: _____

Have you ever had head or neck injury? **Y / N** Describe: _____

Are you taking any medications? **Y / N** Describe:

_____

Are you required to take an **antibiotic/pre-med** before a dental visit? **Y / N**

Are you allergic to any of the following?
(Check all that apply)

Aspirin: ___ Acrylic: ___ Codeine: ___ Latex: ___ Local Anesthetic: ___ Penicillin: ___
Other: _____

Do you have or had any of the following?
(Check all that apply)

Anemia	__	Frequent Headaches	__	Pain in Jaw Joints	__
Angina	__	Genital Herpes	__	Psychiatric Care	__
Arthritis/Gout	__	Glaucoma	__	Renal Dialysis	__
Asthma	__	Heart Trouble	__	Rheumatic Fever	__
Artificial Joint/Limb	__	Heart Pace Maker	__	Radiation Therapy	__
Blood Disease	__	Hepatitis A	__	Recent Weight Loss	__
Breathing Problems	__	Hepatitis B or C	__	Scarlet Fever	__
Cancer	__	High Blood Pressure	__	Sickle Cell	__
Chemotherapy	__	HIV/AID Positive	__	Sinus Trouble	__
Chest Pains	__	Hypoglycemia	__	Stroke	__
Cold Sores	__	Irregular Heart Beat	__	Swelling of limbs	__
Convulsions	__	Kidney Problems	__	Thyroid Disease	__
Diabetes	__	Leukemia	__	Transfusion	__
Digestive Problems	__	Liver Disease	__	Tuberculosis (TB)	__
Drug Addiction	__	Low Blood Pressure	__	Ulcers	__
Emphysema	__	Lung Disease	__	Venereal Disease	__
Excessive Bleeding	__	Mitral Valve Prolapse	__	Other: _____	

Do you use tobacco products in any form? **Y / N** Describe: _____

Do you ever get migraines and/or headaches frequently: **Y / N**

Are you happy with your smile (color/shape of your teeth): **Y / N**

If no, what would you change: _____

For Women Only:

Are you Pregnant? Y / N

Are you trying to get pregnant? Y / N

Are you Nursing? Y / N

Are you taking oral contraceptives? Y / N

To the best of my knowledge, all of the proceeding answers are correct. If I have any changes in my health status or if my medicines change, I shall inform the dentist and/or staff at the next appointment without fail. I hereby authorize the dental office to administer such medication and perform diagnostic and therapeutic procedures as may be necessary for proper dental care. I grant the right of the dentist to release my dental/medical histories and other information about my dental treatment to third party payers and/or other health care professionals.

Signature of Patient or Guardian Date

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Please Handle Me with Care

Please circle the number next to the statement that concerns you or describes your situation:

1. I gag easily.
2. I feel out of control when I'm lying down in the dental chair.
3. I have not been to the dentist for a long time, and I feel uncomfortable about what you will say about my teeth and my dental hygiene.
4. Pain relief is a top priority for me.
5. I don't like shots (or I've had bad reaction to shots).
6. Please tell me what I need to know about my mouth so I am better able to make an informed decision.
7. My teeth are very sensitive.
8. I don't like the sound of that tool that makes the picking and scraping noise. It's like someone is scratching fingernails on a blackboard.
9. I don't like cotton in my mouth.
10. I hate the noise of drill.
11. Please respect my time. I don't want to sit in the reception area for an extended period of time.
12. I want to know the cost upfront. No money surprises.
13. I have difficulty listening and remembering what I hear while sitting in the dental chair.
14. I have health problems and questions that we need to discuss.

The Handle Me with Care Partnership Pact:

I ask that you honestly inform me of all my dental problems. I want you to make me aware of the best quality dentistry available today. Then we can discuss how I can make healthy choices that will work with my budget. I also want to know all the pain relief options available to me in your dental office, how each dental procedure will work, and how much of my time will be required.

Signature of Patient or Guardian Date