44 Adams Street
Braintree, MA 02184
(781) 848-0292
www.southshoresmiles.com

PATIENT INFORMATION

Patient Name: _____ Date: _____
Last First MI Preferred Name

Social Security #: _____ Birth Date: _____ Gender: Male ☐ Female ☐ Family status: _____

Phone (Home): _____ (Mobile): _____ (Work): _____ (Ext): _____

Email: _____

Address: _____
Street Apartment Number

_____
City State Zip Code

EMPLOYMENT INFORMATION

The following is for: ☐ Patient ☐ Person responsible for Payment

Employer Name: _____ Occupation: _____

Address: _____
Street

_____
City State Zip Code

INSURANCE INFORMATION

Name of insured: _____ Is insured a patient? Yes ☐ No ☐
Last First MI

Insured's birth date: _____ ID #: _____ Group #: _____

Address: _____
Street Apartment Number

_____
City State Zip Code

Insured's employer name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

Insurance Plan Name and Address: _____

REFERAL INFORMATION

Who should we thank for referring you to our practice?

☐ Friend/Family ☐ Co-worker ☐ Dental Office ☐ Google ☐ Yelp ☐ Facebook ☐ Post Card ☐ Insurance List

☐ Other: _____

Name of person or office referring you to our practice: _____

DENTAL INFORMATION

Date of last dental visit: _____ Reason for dental visit today: _____

Date of last dental x-rays: _____

Please check all that apply:

☐ Gums bleed when brushed or flossed
☐ Teeth are sensitive to cold, hot, sweets, or pressure
☐ Mouth is dry
☐ Have had periodontal (gum) treatment(s)
☐ Have had orthodontic (braces) treatment(s)
☐ Have had problems associated with previous dental treatment
☐ Home water supply is fluoridated
☐ Currently experiencing dental pain or discomfort
☐ Have earaches and/or neck pains
☐ Have clicking, popping, and/ or general discomfort in your jaw
☐ Do you grind your teeth
☐ Have sores or ulcers in your mouth
☐ Wear dentures or partials
☐ Participate in active/physical recreational activities
☐ Have had a serious injury to your head or mouth

- How do you feel about your smile? _____

  Is there anything you would want to change: _____

  _____

HEALTH INFORMATION

Do you have, or have you had any of the following? Please check all that apply:

☐ Allergies: _____
_____
☐ Anemia
☐ Arthritis
☐ Artificial Joints
☐ Asthma
☐ Blood Disorder
☐ Cancer
☐ Diabetes
☐ Dizziness
☐ Epilepsy
☐ Excessive Bleeding
☐ Fainting
☐ Glaucoma
☐ Growths
☐ Hay Fever
☐ Head Injuries
☐ Heart Disease
☐ Heart Murmur
☐ Hepatitis
☐ High Blood Pressure
☐ HIV
☐ Jaundice
☐ Kidney Disease
☐ Liver Disease
☐ Mental Disorders
☐ Nervous Disorders
☐ Pacemaker
☐ Radiation Treatment
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Rheumatism
☐ Sinus Problems
☐ Stomach Problems
☐ Stroke
☐ Tuberculosis
☐ Tumors
☐ Ulcers
☐ Venereal disease

Other:

☐ _____
☐ _____
☐ _____
☐ _____
☐ _____
☐ _____

Allergies - Are you allergic to, or have you had a reaction to any of the following: *(To all yes responses, please specify type of reaction)*

☐ Local Anesthetics: _____
☐ Aspirin: _____
☐ Latex (rubber): _____
☐ Iodine: _____

☐ Penicillin or Other Antibiotics: _____
☐ Barbiturates, Sedatives, or Sleeping Pills: _____
☐ Sulfa Drugs: _____
☐ Codeine: _____
☐ Metals: _____
☐ Hay Fever / Seasonal: _____
☐ Animals: _____
☐ Food: _____
☐ Other: _____

Additional Questions

- Have you ever had any complications following dental treatment? Yes ☐ No ☐
  If yes, please explain: _____
- Have you been admitted to a hospital or needed emergency care during the past two years? Yes ☐ No ☐
  If yes, please explain: _____
- Are you now under the care of a physician? Yes ☐ No ☐
  If yes, please explain: _____
  Name of Physician: _____ Phone: _____
- Do you have any health problems that need further clarification? Yes ☐ No ☐
  If yes, please explain: _____
- Are you taking Fosamax or other Bisphosphonate (anti-osteoporosis) drugs? Yes ☐ No ☐
  If yes, for how long: _____
- Are you taking any prescription medications, over the counter medications, herbs, or supplements? Yes ☐ No ☐
  If yes, please explain: _____
- Are you: Pregnant ☐ Nursing ☐ On Hormone Therapy ☐ On Birth Control Medication ☐
  Due Date: _____
- Do you currently or have you ever used tobacco products? Yes ☐ No ☐
- Joint Replacement: Have you had an orthopedic total joint replacement (hip, knee, elbow, or finger)? Yes ☐ No ☐
  Date: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at my next appointment without fail.

_____ Date: _____
Signature of Patient, Parent, or Guardian

CONSENT FOR SERVICES

I give consent to South Shore Smiles to submit a claim for any specialist service rendered to me. It is fully understood that the provider of services may not participate with my insurance nor is a reimbursement of out-of-pocket costs expected. It is fully understood that this office will help prepare the patient's insurance forms or assist in making collections from insurance companies that South Shore Smiles participates with and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. Because your insurance reserves the right not to pay a claim due to their statutes of limitations, the patient is responsible to understand the parameters of their insurance, and is responsible, at the time of the visit, for any expenses incurred that are not covered by their plan, as well as deductibles that may be due at the time of service. It is fully understood that if South Shore Smiles does not participate with my insurance, all fees for services rendered must be paid for at the time services are performed.

By signing below, I give consent to South Shore Smiles to administer dental treatment for myself or to my child. I understand that if my child is under the age of 18, I must be present at each visit.

Our office contacts patients by phone, email, or text 48 hours prior to each appointment. Failure to respond to a reminder message within 48 hours will be considered a cancellation. Please note: 48-hour notice is required for all cancelled appointments. One exception is allotted per year. A second cancellation (without notice) will result in a mandatory deposit to schedule an appointment. Continued missed appointments may result in dismissal from the practice.

I received, reviewed, and signed, where appropriate, all South Shore Smiles new patient forms.
I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.
I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to the Patient: _____
Signature of Patient, Parent, or Guardian