



SHORE FAMILY
D E N T I S T R Y

Ijeoma Tagbo, DMD, FAGD

Improving the smiles of the community, one family at a time.

Patient Information

Date: _____

Patient Name _____ SS# _____ Birthdate ____/____/____
Last Name First Name

Gender M F Age _____ Nickname/Preferred Name _____ Occupation _____

Home Phone _____ Cell _____ Email Address _____

Mailing Address _____
Street City State Zip

How did you hear about our practice? _____ Friend's Name (If Applicable) _____

Emergency Contact _____ Phone Number _____

Responsible Party

Name of person responsible for this account (if someone other than yourself) _____
Last Name First Name

Relationship _____ Driver's Licence # _____ SS# _____ Birthdate ____/____/____

Home Phone _____ Cell _____ Email Address _____

Address _____
Street City State Zip

Employer _____ Work Phone _____

Is this person currently a patient in our office? Yes No

Insurance Information

Primary

Do you have insurance to assist you with payment? Yes No

ID # _____

Name of Insured _____

Relationship _____ SS# _____

Birthdate ____/____/____ Work Phone _____

Employer _____

Employer Address _____

Insurance Company _____ Group # _____

Do you have a deductible? Yes No I'm not sure

Do you know your maximum annual benefit? Yes Amount \$ _____ No

Have you used this insurance at a dental practice before? Yes No

Secondary

Do you have insurance to assist you with payment? Yes No

ID # _____

Name of Insured _____

Relationship _____ SS# _____

Birthdate ____/____/____ Work Phone _____

Employer _____

Employer Address _____

Insurance Company _____

Do you have a deductible? Yes No I'm not sure

Do you know your maximum annual benefit? Yes Amount \$ _____ No

Have you used this insurance at a dental practice before? Yes No



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Practice Financial Policy

We are committed to providing you and your family with the best possible care and are pleased to discuss our professional fees and your insurance coverage with you at any time. Your clear understanding of our financial and insurance policies is important to our relationship.

- All patients must complete and sign the Patient Registration and History form before seeing the Doctor.
- We accept most insurance plans and will gladly process your claim. Please notify us of any changes in your insurance plan and bring your current insurance card to each visit. Insurance policies generally cover only a portion of the total treatment cost. Unless other arrangements have been made, we ask that you pay your portion of the bill at the time of treatment. It is your responsibility to pay any balance not paid by your insurance company.
- For your convenience, we accept cash, personal checks, Visa, MasterCard and Discover. Financing is also available through Care Credit.
- Twenty-four hour notice is required when re-scheduling or canceling an appointment. A cancellation fee of \$25.00 may be charged for broken appointments with less than twenty-four hour notice.
- Treatment plans may change, and you will be responsible for the treatment actually completed.
- For your convenience, this office may release your information to your insurance company, and receive payment directly from them. Every effort will be made to help you process your insurance claim, however, the insurance company, not our office, determines the dental benefits that you receive. The estimated insurance coverage is not a guarantee of payment and is between you and the insurance company. All charges are your responsibility. Please keep your insurance information current by notifying us of any changes in employment and insurance coverage.
- If sent to collections, you understand that it is your full financial responsibility to pay all court costs and all collection fees and/or attorneys fees.

I authorize the dentist to release any information including diagnosis and the records of any treatment or examination rendered to me during the period of such dental care to third party payors. I authorize and hereby request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me. I am responsible for payment regardless of insurance company's arbitrary determination of reasonable and customary rates. I understand that payment is expected when services are rendered unless other arrangements are made in advance.
I have been given a copy of the HIPAA.

Patient Name _____ Birthdate ____/____/____

Signature of Parent or Guardian (if applicable) Date: _____



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Medical History

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions. Your answers would be kept confidential subject to applicable laws.

Are you under a physician's care now? Yes No If Yes, fill out 1a and 1b

1a) Name of physician? _____

1b) Address and Phone of Physician _____

Have you ever been hospitalized or had a major operation? Yes No If Yes, please explain _____

Have you ever had a serious head or neck injury? Yes No If Yes, please explain _____

Are you taking any prescription or over the counter medications? Yes No If Yes, please list all including natural or herbal preparations and diet supplements: _____

Do you take or have you taken, Phen-Fen or Redux? Yes No If Yes, please explain _____

Are you on a special diet? Yes No If Yes, please explain _____

Do you use controlled substances? Yes No If Yes, please explain _____

Are you allergic to any of the following?

Aspirin Penicillin Codeine Sulfa drugs Acrylic Metal Latex Local Anesthetics Other _____

Women Only: Are you: Pregnant/Trying to get pregnant? Yes No Taking Oral Contraceptives? Yes No Nursing? Yes No

Please indicate if you have, or have had, any of the following conditions:

- | | | | | |
|---|--|--|---|---|
| <input type="checkbox"/> AIDS/HIV Positive | <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Seasonal Allergies |
| <input type="checkbox"/> Alzheimer's Disease | <input type="checkbox"/> Cold Sores/Fever Blisters | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Sexually Transmitted Disease |
| <input type="checkbox"/> Anaphylaxis | <input type="checkbox"/> Congenital Heart Disorder | <input type="checkbox"/> Heart Attack/Failure | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Cortizone Medicine | <input type="checkbox"/> Heart Pace Maker | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Arthritis/Gout | <input type="checkbox"/> Diabetes Type (I or II) | <input type="checkbox"/> Heart Trouble/Disease | <input type="checkbox"/> Pain in Jaw Joints | <input type="checkbox"/> Spina Bifida |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Parathyroid Disease | <input type="checkbox"/> Stomach/Intestinal Disease |
| <input type="checkbox"/> Artificial Joint | <input type="checkbox"/> Easily Winded | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Psychiatric Care, Please | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Hepatitis B or C | Explain: _____ | <input type="checkbox"/> Swelling of Limbs |
| <input type="checkbox"/> Autoimmune Disease | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Herpes | <input type="checkbox"/> Radiation Treatments | <input type="checkbox"/> Systemic Lupus Erythematosus |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Recent Weight Loss/Gain | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Hives or Rash | <input type="checkbox"/> Reflux | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Excessive Thirst | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Renal Dialysis | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Breathing Problem | <input type="checkbox"/> Fainting Spells/Dizziness | <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Tumors or Growths |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Frequent Cough | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Rheumatic Heart Disease | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Rheumatoid arthritis | <input type="checkbox"/> Yellow Jaundice |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Genital Herpes | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Scarlet Fever | |

Have you had any serious illness not listed above? Yes No If yes, please explain _____

Signature

To the best of my knowledge the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform Shore Family Dentistry of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

For Completion by Dentist



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P. 443-385-0285 F. 443-385-0286

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Dental History

How long since you have seen a dentist? _____

Name of Previous Dentist? _____ City _____ State _____

- Yes No Are you having **problems** now? If Yes, please explain _____
- Yes No Are you apprehensive about dental treatment?
- Yes No Have you ever been pre-medicated with antibiotics before dental treatment?
- Yes No Do you wear **Dentures**? (Partials or Full)
- Yes No Are you **Unhappy** with your dentures?
- Yes No Have you had any **Periodontal** (Gum) treatment?
- Yes No Do your gums **Bleed**, or feel **Tender** or **Irritated**?
- Yes No Are you teeth **Sensitive** to hot, cold, sweets, pressure?
- Yes No Are you **Unhappy** with the **Appearance** of your teeth?
- Yes No Do you have **Headaches, Earaches, or Neck Pains**?
- Yes No Are you aware of **Clenching** or **Grinding** your teeth?
- Yes No Have you worn **Braces** on your teeth (Orthodontic)?
- Yes No Do you have **Discolored** teeth that bother you?
- Yes No Do you use tobacco (smoking, snuff, chew, bidis)? If Yes, how long? _____ How much? _____
How interested are you in stopping (circle one) VERY / SOMEWHAT / NOT INTERESTED
- Yes No Do you drink alcoholic beverages? If Yes, how much typically in day _____ /week _____
- Yes No Do you have a dry mouth?
- Yes No Do you drink sodas or sports drinks? If Yes, how often? _____
- Yes No Do you chew gum, suck on hard candy or cough drops? If Yes, how often? _____
- Yes No Do you get fever blisters or cold sores? If Yes, how often? _____

Please rank the following in the order in which they would keep you from accepting dental treatment.

#_____ Cost of Treatment #_____ Lack of concern #_____ Fear of pain #_____ Convenience