SHORE FAMILY
DENTISTRY
Ijeoma Tagbo, DMD, FAGD

29466 Pintail Dr. #16 Easton, MD 21601
P. 443-385-0285 F. 443-385-0286

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

Patient Information

Date: _____

Patient Name _____ (Last Name) _____ (First Name) SS# _____ Birthdate ___/___/___

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 ___/___/____

_____ Date: _____

Signature of Parent or Guardian (if applicable)

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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:

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

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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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