SCARBOROUGH DENTAL ASSOCIATES, P.A.
243 U.S. ROUTE ONE, SUITE #2 SCARBOROUGH, MAINE 04074
MICHAEL F. FARINO, D.M.D.
JONATHAN M. SHINAY, D.M.D.

PATIENT INFORMATION (PLEASE PRINT)

NAME:_____ Male□ / Female□ DATE:_____

NICKNAME: _____S S # : _____

DATE OF BIRTH: _____ HOME PHONE: _____

ADDRESS: _____

CITY: _____STATE: _____ZIP: _____

EMAIL ADDRESS:_____

EMPLOYER: _____OCCUPATION: _____

BUSINESS ADDRESS: _____BUSINESS PHONE: _____

SPOUSE'S NAME: _____S S # : _____

SPOUSE'S EMPLOYER: _____

ACCOUNT INFORMATION – PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT

NAME: _____S S # : _____

DATE OF BIRTH: _____RELATION TO PATIENT: _____

PHONE: _____ADDRESS: _____

EMPLOYER: _____BUSINESS PHONE: _____

EMERGENCY INFORMATION

NAME: _____ PHONE: _____

DENTAL INSURANCE INFORMATION (PRIMARY CARRRIER)

INSURED'S NAME: _____S S #: _____

DATE OF BIRTH: _____GROUP # : _____POLICY #: _____

INSURANCE CO. NAME: _____

ADDRESS: _____

PHONE: _____

DENTAL INSURANCE INFORMATION (SECONDARY CARRIER)

INSURED'S NAME: _____S S # : _____

DATE OF BIRTH: _____ GROUP #: _____POLICY #: _____

INSURANCE CO. NAME: _____

ADDRESS: _____

PHONE: _____

I assign insurance benefits directly to Scarborough Dental Associates, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

I understand that I am responsible for all fees. I understand that in the event my payments are not received within 30 days of their due date, a monthly charge of 1 ½ % will be applied to my account.

Signature: _____
(Patient/guardian)

CHILD DENTAL MEDICAL HISTORY

PATIENT'S NAME: (PRINT)_____
DATE OF BIRTH: _____

PARENT'S NAMES: (PRINT)_____

DENTAL HISTORY *(PLEASE CIRCLE YES OR NO)*

IS THIS THE CHILDS FIRST VISIT TO THE DENTIST?	YES	NO
IF NO, HOW LONG SINCE THE LAST VISIT TO THE DENTIST? _____		
DOES THE CHILD EAT BETWEEN MEALS?	YES	NO
DOES THE CHILD EAT SWEETS – CANDY, CHEWING GUM, SODA	YES	NO
DOES THE CHILD EAT WELL-BALANCED MEALS?	YES	NO
DOES THE CHILD BRUSH TEETH IN THE MORNING?	YES	NO
DOES THE CHILD BRUSH TEETH BEFORE GOING TO BED?	YES	NO
DOES THE CHILD BRUSH AFTER EACH MEAL?	YES	NO
DO YOU LIVE IN AN AREA WITHOUT FLUORINATED WATER?	YES	NO
HAS THE CHILD'S TEETH BEEN TREATED WITH FLUORIDE?	YES	NO
HAVE ANY CAVITIES BEEN NOTED IN THE PAST?	YES	NO
WERE ANY BABY OR PERMANENT TEETH REMOVED BY EXTRACTION?	YES	NO
ANY INJURIES TO TEETH? (FALLS, BLOWS, CHIPS)	YES	NO
HAS THE CHILD HAD ANY UNFAVORABLE DENTAL EXPERIENCES?	YES	NO
HOW MANY CHILDREN IN YOUR FAMILY? _____		
ANY ORTHODONTIC TREATMENT IN YOUR FAMILY?	YES	NO
HAS THE CHILD EVER RECEIVED A LOCAL ANESTHETIC?	YES	NO
HAS THE CHILD EVER HAD OCCLUSAL SEALANTS?	YES	NO

MEDICAL HISTORY

IS THE CHILD IN GOOD HEALTH?	YES	NO
IS THE CHILD UNDER THE CARE OF A PHYSICIAN?	YES	NO
IF YES – SINCE WHEN AND FOR WHAT? _____		
WHAT IS THE NAME OF THE PHYSICIAN? _____		
HAS THE CHILD HAD ANY SERIOUS ILLNESS?	YES	NO
WHEN? _____ WHY? _____		
HAS THE CHILD HAD ANY SURGERY?	YES	NO
IF YES, WHAT KIND? _____		
IS SURGERY CONTEMPLATED?	YES	NO
IS THE CHILD SUBJECT TO PROFUSE BLEEDING?	YES	NO
IS THE CHILD SUBJECT TO NERVOUS DISORDERS – FAINTING – DIZZINESS	YES	NO
DOES THE CHILD HAVE ANY ALLERGIES?	YES	NO
IS THE CHILD ALLERGIC TO PENICILLIN OR ANY OTHER DRUGS?	YES	NO
IS THE CHILD TAKING ANY MEDICATION?	YES	NO

HAS THE CHILD HAD A HISTORY OF: *(CIRCLE APPROPIATE RESPONSES)*

DIABETES HEART TROUBLE
ASTHMA KIDNEY INFECTION RHEUMATIC FEVER
TOOTHACHE EAR INFECTION

I CERTIFY THAT THE INFORMATION ABOVE IS COMPLETE AND ACCURATE

PARENT'S / GUARDIAN'S SIGNATURE: _____ DATE: _____