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: _____ MARITAL STATUS: _____

ADDRESS: _____HOME PHONE: _____

CITY: _____STATE: _____ZIP: _____ CELL PHONE: _____

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 – WHO SHOULD WE CONTACT IN CASE OF AN EMERGENCY?

NAME: _____ PHONE: _____

DENTAL INSURANCE INFORMATION (PRIMARY CARRIER)

INSURED'S NAME: _____ID #: _____

DATE OF BIRTH: _____GROUP # : _____POLICY #: _____

INSURANCE CO. NAME: _____

ADDRESS:_____

PHONE: _____

DENTAL INSURANCE INFORMATION (SECONDARY CARRIER)

INSURED'S NAME: _____ID # :_____

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)

PATIENT DENTAL HISTORY **– THIS INFORMATION IS CONFIDENTIAL**

YOUR NAME _____

STATE BRIEFLY THE REASON FOR THIS VISIT: _____
DO YOU HAVE DISCOMFORT IN YOUR MOUTH NOW? _____
IF SO, WHAT LOCATION? _____
HOW LONG SINCE YOUR LAST DENTAL VISIT? _____
DID YOU HAVE X-RAYS TAKEN? _____
DOES DENTAL TREATMENT MAKE YOU NERVOUS? PLEASE CIRCLE ONE
NO - SLIGHTLY - MODERATELY - EXTREMELY
HOW MANY TIMES A DAY DO YOU BRUSH YOUR TEETH? _____
WHAT TYPE OF TOOTHBRUSH DO YOU USE? SOFT - MEDIUM - HARD
DO YOU FLOSS YOUR TEETH? _____ HOW OFTEN? _____
NAME OF YOUR PREVIOUS DENTIST: _____
TELEPHONE: _____

PLEASE CIRCLE YES OR NO TO THE FOLLOWING QUESTIONS

- DO YOUR GUMS BLEED - FEEL TENDER - OR IRRITATED? YES NO
- ARE YOUR TEETH SENSITIVE TO HOT - COLD - SWEETS? YES NO
- DOES FOOD IMPACT BETWEEN CERTAIN TEETH? YES NO
- ARE ANY TEETH LOOSE? YES NO
- DO YOU GRIND OR CLENCH YOUR TEETH DURING THE NIGHT OR DAY? YES NO
- DOES YOUR JAW CLICK OR CAUSE PAIN WHEN OPENING OR CLOSING? YES NO
- HAVE YOU EVER HAD ROOT CANAL TREATMENT? YES NO
- HAVE YOU EVER HAD GUM TREATMENT? YES NO

- HAVE YOU EVER HAD SORE SPOTS OR GROWTHS IN YOUR MOUTH? YES NO
- DO YOU HAVE ANY UNHEALED OR INFLAMED AREAS IN YOUR MOUTH? YES NO
- DO YOU HAVE AN UNPLEASANT TASTE IN YOUR MOUTH? YES NO
- DO YOU HAVE PAIN IN OR NEAR YOUR EARS? YES NO
- DO YOU EVER BITE YOUR CHEEKS OR YOUR LIPS? YES NO

- HAVE YOU EVER HAD INSTRUCTIONS ON THE CORRECT METHOD OF BRUSHING YOUR TEETH? YES NO
- HAVE YOU EVER HAD INSTRUCTIONS ON THE CARE OF YOUR GUMS? YES NO
- DID YOU EVER WEAR BRACES? YES NO
- HAVE YOU EVER HAD NOVOCAINE ANESTHETIC? YES NO
- IF SO, DID YOU HAVE ANY REACTIONS OR ALLERGIC SYMPTOMS FROM IT? YES NO
- HAVE YOU EVER HAD ANY TEETH EXTRACTED? YES NO

PATIENT MEDICAL HISTORY – UPDATE (ALL INFORMATION IS STRICTLY CONFIDENTIAL)

- ❑ DATE OF LAST PHYSICAL EXAM? _____
- ❑ NAME OF YOUR PHYSICIAN AND TELEPHONE: _____
- ❑ ARE YOU CURRENTLY UNDER THE CARE OF YOUR DOCTOR? _____
- ❑ FOR WHAT REASON? _____
- ❑ ARE YOU NOW TAKING ANY DRUGS OR MEDICATIONS? _____
- ❑ IF SO, WHAT ARE YOU TAKING? _____
- ❑ _____
- ❑ HAVE YOU EVER HAD ANY ALLERGIC REACTIONS TO ANY MEDICATIONS INCLUDING
- ❑ PENICILLIN – CODEINE – ASPIRIN? _____IF SO WHAT? _____
- ❑ HAS THERE BEEN A CHANGE IN YOUR HEALTH IN THE PAST YEAR? _____
- ❑ ARE YOU IN GENERAL GOOD HEALTH AT THIS TIME? _____

HAVE YOU EVER BEEN HOSPITALIZED, HAD A MAJOR OPERATION, OR ILLNESS? _____

- ❑ IF SO, WHAT? _____
- ❑ HAVE YOU EVER HAD A SERIOUS ACCIDENT INVOLVING HEAD INJURIES? _____
- ❑ DO YOU HAVE SHORTNESS OF BREATH \ CHEST PAIN UPON EXERTION? _____
- ❑ DO YOU HAVE NIGHT SWEATS ACCOMPANIED BY WEIGHT LOSS OR COUGH? _____
- ❑ DO YOU HAVE A HISTORY OF FAINTING AND\OR SEIZURES? _____
- ❑ HAVE YOU EVER HAD ABNORMAL BLEEDING PROBLEMS AFTER A CUT? _____
- ❑ HAVE YOU EVER HAD A BLOOD TRANSFUSION? _____

HAVE YOU EVER HAD A KIDNEY DIALYSIS TREATMENT? _____

- ❑ ARE YOU ALLERGIC TO ANY KNOWN MATERIALS RESULTING IN HIVES – ASTHMA –
- ❑ ECZEMA – ETC.? _____ARE YOU DIETING? _____
- ❑ ARE YOU ALLERGIC TO LATEX? _____ARE YOU ALLERGIC TO NOVOCAINE?_____
- ❑ DO YOU SMOKE AND\OR CHEW TOBACCO? _____
- ❑ ARE YOU RECOVERING FROM ANY TYPE OF CHEMICAL DEPENDENCY? _____

WOMEN ONLY: ARE YOU TAKING BIRTH CONTROLL PILLS ____ARE YOU PREGNANT?___NO.of wks_____
ESTIMATED DATE OF DELIVERY: _____ ARE YOU NURSING? _____

MEDICAL CONDITIONS: (PLEASE **CIRCLE YES OR NO** TO ALL LISTED)

HEART MURMUR	YES	NO	HEPATITIS / YELLOW JAUNDICE	YES	NO
RHEUMATIC FEVER	YES	NO	AIDS / HIV POSITIVE	YES	NO
HEART AILMENT	YES	NO	KIDNEY DISEASE	YES	NO
MITRAL VALVE PROLAPSE	YES	NO	STOMACH / INTESTINAL ULCERS	YES	NO
ANGINA	YES	NO	TUMORS OR GROWTHS	YES	NO
PACEMAKER	YES	NO	DIABETES	YES	NO
STROKE	YES	NO	RESPIRATORY DISEASE	YES	NO
HEMOPHILIA	YES	NO	EPILEPSY	YES	NO
RADIATION TREATMENTS	YES	NO	VENEREAL DISEASE	YES	NO
ASTHMA	YES	NO	RHEUMATISM / ARTHRITIS	YES	NO
LIVER DISEASE	YES	NO	ANEMIA	YES	NO
TUBERCULOSIS	YES	NO	BLOOD DISEASE	YES	NO
HIGH BLOOD PRESSURE	YES	NO	SINUS TROUBLE	YES	NO
JOINT REPLACEMENT	YES	NO			

DO YOU HAVE ANY DISEASE, CONDITION OR PROBLEM NOT LISTED? _____
IF SO, PLEASE EXPLAIN: _____

- ❑ TO THE BEST OF MY KNOWLEDGE, ALL THE PRECEDING ANSWERS ARE TRUE AND CORRECT. IF I HAVE ANY CHANGES IN MY HEALTH OR MEDICATION, I WILL INFORM MY DENTIST AT MY NEXT APPOINTMENT.

SIGNATURE: _____DATE: _____

PRINT NAME: _____