EASTERN SHORE SMILE SOLUTIONS
Personalized & Comfortable Care • It's All About You

Patient Registration

Date:_____

Patient Information

Name_____ Date of Birth_____
Male Female Single Married Divorced Separated Widowed Minor
Social Security Number:_____ Home Phone:_____
Home Address_____ Work Phone:_____
_____ Cell Phone:_____
How would you like to be contacted?_____ Email_____
Emergency Contact:_____ Phone#_____
Employed by_____
Referred by_____

Responsible Party (If other then Patient)

Person Responsible for Account_____ Date of Birth_____
Patient of Record Yes No Relationship to Patient_____
Home Address_____ Home Phone_____
_____ Cell Phone_____
Employer_____ Work Phone_____

Dental Insurance Information

	Primary	Secondary
Dental Insurance Company	_____	_____
Policyholder	_____	_____
Date of Birth	_____	_____
Social Security Number	_____	_____
Member ID Number	_____	_____
Group Number	_____	_____
Employer	_____	_____

Authorization

To avoid misunderstanding regarding dental insurance, we would like to make you aware that your insurance coverage is a contract between you and your insurance company. We will provide the necessary forms to your insurance company, provided that you pay the necessary copays at the time treatment is rendered, and then any remaining balance after your insurance benefits are received. If you are not using dental insurance, all fees will be collected at date of service.

Any appointment that our staff schedules for you and/or your family member(s) is reserved exclusively for you. A minimum charge or deposit will be made for failed or cancelled appointment without prior notification of 48 hours.

_____ _____
Patient Signature Date

_____
Guardian's Signature (if under 18 years of age)

Eastern Shore Smile Solutions
17 Franklin Street, Cambridge, MD 21613 ● 29276 Erickson Drive, Easton, MD 21601
www.EasternShoreSmileSolutions.com ● **P**hone: (410) 228-4191 ● **F**ax: (877) 712-4781

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COMPREHENSIVE MEDICAL HISTORY

First and Last Name_____Birth Date _____/_____/_____
(please print) month day year

Allergies

❑No Known Allergies
❑Antibiotics
❑Aspirin
❑Barbiturates
❑Codeine
❑Iodine
❑Latex
❑Local Anesthetics
❑Metals
❑Penicillin
❑Plastic
❑Sedatives
❑Sleeping Pills
❑Sulfa Drugs
❑Tetracycline

Current Medications

Medicine	Dosage/Frequency	Reason

Medical History

Medical Condition	Never/Current/Past			Notes	Medical Condition	Never/Current/Past			Notes
Acid Reflux	❑	❑	❑		Hepatitis	❑	❑	❑	
Anemia	❑	❑	❑		Hypoglycemia	❑	❑	❑	
Arteriosclerosis	❑	❑	❑		Immune System Disorder	❑	❑	❑	
Arthritis	❑	❑	❑		Ischemic Heart Disease	❑	❑	❑	
Asthma	❑	❑	❑		Kidney Problems	❑	❑	❑	
Autoimmune Disorder	❑	❑	❑		Liver Disease	❑	❑	❑	
Bleeding Easily	❑	❑	❑		Meniere's Disease	❑	❑	❑	
Blood Pressure-High	❑	❑	❑		Mitral Valve Prolapse	❑	❑	❑	
Blood Pressure-Low	❑	❑	❑		Multiple Sclerosis	❑	❑	❑	
Bruising Easily	❑	❑	❑		Muscular Dystrophy	❑	❑	❑	
Cancer	❑	❑	❑		Mood Disorder	❑	❑	❑	
Chemotherapy	❑	❑	❑		Nasal Allergies	❑	❑	❑	
Chronic Fatigue	❑	❑	❑		Neuralgia	❑	❑	❑	

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Medical Condition	Never/Current/Past			Notes	Medical Condition	Never/Current/Past			Notes
Chronic Pain	❑	❑	❑		Osteoarthritis	❑	❑	❑	
COPD	❑	❑	❑		Osteoporosis	❑	❑	❑	
CPAP/BiPAP	❑	❑	❑		Parkinson's Disease	❑	❑	❑	
Depression	❑	❑	❑		Pregnancy	❑	❑	❑	
Diabetes	❑	❑	❑		Psychiatric Care	❑	❑	❑	
Difficulty Sleeping	❑	❑	❑		Radiation Treatment	❑	❑	❑	
Dizziness	❑	❑	❑		Rheumatic Fever	❑	❑	❑	
Emphysema	❑	❑	❑		Rheumatoid Arthritis	❑	❑	❑	
Epilepsy	❑	❑	❑		Sinus Problems	❑	❑	❑	
Fibromyalgia	❑	❑	❑		Sleep Apnea	❑	❑	❑	
Glaucoma	❑	❑	❑		Snoring	❑	❑	❑	
Gout	❑	❑	❑		Stroke	❑	❑	❑	
Heart Attack	❑	❑	❑		Tendency for Ear Infections	❑	❑	❑	
Heart Disorder	❑	❑	❑		Thyroid disorder	❑	❑	❑	
Heart Murmur	❑	❑	❑		Tuberculosis	❑	❑	❑	
Heart Pacemaker	❑	❑	❑		Tumors	❑	❑	❑	
Heart Valve Replacement	❑	❑	❑		Urinary Disorders	❑	❑	❑	
Hemophilia	❑	❑	❑		Prior Orthodontic Treatment	❑	❑	❑	
Please list any additional Medical Conditions:									
	❑	❑	❑			❑	❑	❑	
	❑	❑	❑			❑	❑	❑	
	❑	❑	❑			❑	❑	❑	
☐**Confidential Medical History:**									
Recreational Drug Use	❑	❑	❑		HIV/AIDS	❑	❑	❑	

I agree that the information provided above is to the best of my knowledge.

Name_____
Date_____

(Patient's Signature)

_____

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