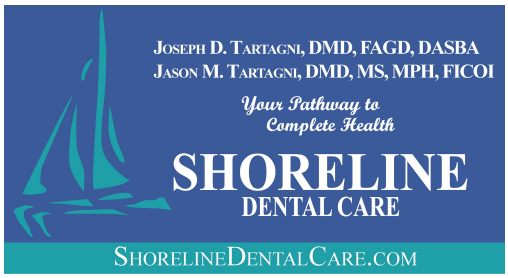

Welcome to Shoreline Dental Care LLC. We appreciate your confidence in our dental health team and pledge to provide you with the highest level of professional care possible. In order to help us ensure your health and comfort, we ask that you complete the following form. All information will be held in the strictest confidence. If you have any questions or require help, please ask and we will be happy to assist you.

New Patient Information *(Confidential)*

Date:_____

Patient Name:_____

Nickname: _____

Address:_____

City:_____ State: _____ Zip Code:_____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Other: _____

Email Address:_____

Date of Birth:_____ SS#:_____

Occupation:_____

Employer:_____

Business Address:_____

City:_____ State: _____ Zip Code:_____

Name of Spouse ☐ or Parent ☐:_____

Date of Birth:_____ SS#:_____

Address (if different from above):_____

City:_____ State: _____ Zip Code:_____

Please check appropriate boxes below

Are you ☐ Male ☐ Female

Are you ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Are you ☐ Head of Household ☐ Spouse ☐ Dependent

Children Residing in Household

Name:_____ Age:_____
Name:_____ Age:_____
Name:_____ Age:_____
Name:_____ Age:_____
Name:_____ Age:_____

Medical Information

	YES	NO
Are you currently under the care of a physician?	☐	☐
If yes, please provide the following:		
Physician Name:_____		
Phone:_____Fax:_____		
Date of last physical:_____		
Have you ever been hospitalized in the past five years for any Serious illness or surgeries?	☐	☐
If yes, please explain:_____		
_____		
Are you currently under the care of any additional physicians?	☐	☐
Physician Name:_____Phone:_____		
Physician Name:_____Phone:_____		

Emergency Information:

Who do we contact in case of an emergency?

Name:_____

Phone:_____

Relationship:_____

Name of individual responsible for patient if other than patient:

_____

Other:

How did you learn about Shoreline Dental?

☐ Insurance Guide or Booklet
☐ Office Location
☐ Google
☐ Mailer
☐ Facebook
☐ Website
☐ Other:_____
☐ Referral

Please tell us who referred you so we can thank them for sending you to us:

_____

Signature of Patient or Legal Guardian:_____

In accordance with the Red Flag Rule, we ask that you allow us to retain a copy of your valid photo ID for identification purposes. Thank you.