We are complimented that you have selected us to provide dental care for you and your family.

Patient Information

Date _____ Patients Name _____ (Last) (First) (Middle)

(If patient is a full time student fill in school name) _____ Email Address _____

Address _____ (Street) (City) (State) (Zip)

Home Phone _____ Birthdate _____ Social Security # _____

If patient is a minor, give parent's or guardian's name _____

Whom may we thank for referring you to our office? _____

Emergency Contact: _____

Relationship to Patient: _____ Phone _____

Responsible Party Information

Name _____ (Last) (First) (Middle) (Marital Status)

Residence _____ (Street) (City) (State) (Zip)

Mailing Address _____ (Street) (City) (State) (Zip)

How long at this address _____ Home Phone _____ Work Phone _____

Previous Address (If less than 3 years) _____ (Street) (City) (State) (Zip)

Social Security # _____ Birthdate _____ Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

Employer Address _____

Spouse's Name _____ (Last) (First) (Middle) Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

Employer Address _____

Social Security # _____ Birthdate _____ Work Phone _____

Insurance Information

Insured's Name _____ Insured's Soc. Sec. # _____

Insurance Company _____ Group No. _____

Insurance Co. Address _____ Ph. # _____

Is policy connected with your union? Yes _____ No _____ Name of Union _____ Local No. _____

Do you have dual coverage? Yes _____ No _____ If yes: **Please complete the following secondary insurance information.**

Insured's Name _____ Insured's Soc. Sec. # _____

Insurance Co. _____ Group No. _____ Local No. _____

Insurance Co. Address _____ Ph. # _____

Insured's Employer _____ Ph. # _____

Dental Information

Do your gums bleed when you brush? Yes _____ No _____

Are your teeth sensitive to heat or cold? Yes _____ No _____ Pressure Yes _____ No _____ Sweets Yes _____ No _____

Do you grind or clench your teeth? Yes _____ No _____

Do you have any fear of dental work? Yes _____ No _____

Date of last dental examination _____ What was done at that time? _____

How would you describe your current dental problem? _____

How do you feel about the appearance of your teeth? _____

Please complete back page

Medical Information

1. Are you having pain or discomfort at this time? ..... YES NO
2. Have you been a patient in the hospital during the past two years? ..... YES NO
3. Have you been under the care of a medical doctor during the past two years? ..... YES NO
   Physician's Name _____ Phone No. _____
   Address _____
4. Have you taken any medication or drugs during the past two years? ..... YES NO
5. Are you now taking any medication or drugs? ..... YES NO
   If yes, please list: _____
6. Are you sensitive or allergic to any medication or anesthetics? ..... YES NO
   If yes, please list: _____
7. Indicate which of the following you have had or have at present. Circle "yes or "no" to each item.

Heart Failure	YES	NO	Artificial Joints (hip, knee, etc.)	YES	NO	Allergy to Latex	YES	NO
Heart Disease or Attack	YES	NO	Kidney Trouble	YES	NO	Hepatitis B (serum)	YES	NO
Angina Pectoris	YES	NO	Ulcers	YES	NO	Venereal Disease	YES	NO
Congenital Heart Disease	YES	NO	Diabetes	YES	NO	A.I.D.S.	YES	NO
Heart Murmur	YES	NO	Thyroid Problems	YES	NO	H.I.V. Positive	YES.	NO
High Blood Pressure	YES	NO	Glaucoma	YES	NO	Cold Sores/Fever Blisters	YES	NO
Arteriosclerosis	YES	NO	Cancer	YES	NO	Blood Transfusion	YES	NO
Mitral Valve Prolapse	YES	NO	Emphysema	YES	NO	Hemophilia	YES	NO
Artificial Heart Valve	YES	NO	Chronic Cough	YES	NO	Anemia	YES	NO
Heart Pacemaker	YES	NO	Tuberculosis	YES	NO	Sickle Cell Disease	YES	NO
Heart Surgery	YES	NO	Asthma	YES	NO	Bruise Easily	YES	NO
Rheumatic Fever	YES	NO	Hay Fever	YES	NO	Liver Disease	YES	NO
Arthritis	YES	NO	Allergies or Hives	YES	NO	Yellow Jaundice	YES	NO
Rheumatism	YES	NO	Sinus Trouble	YES	NO	Epilepsy or Seizures	YES	NO
Cortisone Medicine	YES	NO	Radiation Therapy	YES	NO	Fainting or Dizzy Spells	YES	NO
Drug Addiction	YES	NO	Chemotherapy	YES	NO	Nervousness	YES	NO
Stroke	YES	NO	Hepatitis A (infectious)	YES	NO	Tumors	YES	NO
						Developmentally Disabled	YES	NO

8. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or because you are very tired? ..... YES NO
9. Do your ankles swell during the day? ..... YES NO
10. Do you use more than two pillows to sleep? ..... YES NO
11. Have you lost or gained more than 10 pounds in the past year? ..... YES NO
12. Do you ever wake up from sleep and feel short of breath? ..... YES NO
13. Are you on a special diet? ..... YES NO
14. Do you have or have you had any disease, condition, or problem not listed? ..... YES NO
    If yes, please list: _____

FOR WOMEN ONLY:

Are you pregnant? ☐ Yes, what month? _____ ☐ No Are you nursing? ☐ Yes ☐ No Are you taking birth control pills? ☐ Yes ☐ No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

Patient Signature _____ Date _____

CONSENT:

1. The undersigned hereby authorizes doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of the patient's dental needs.
2. I also authorize doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment in connection with (name of patient) _____. I understand that using anesthetic agents embodies a certain risk. Futhermore, I authorize and consent that doctor choose and employ such assistance as deemed fit to provide recommended treatment.
3. I understand that all responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless other arrangements have been made.
4. I understand that it is my responsibility to advise your office of any changes in the information contained on this form.

Patient _____ Date _____ Witness _____

Parent or Responsible Party _____ Relationship to Patient _____

FOR OFFICE USE: Reviewed by Dr. _____ Date: _____

HIPPA Privacy Policy-Acknowledgment

We keep a record of the health care services we provide you. You may ask to see and to have a copy of these records. You may also ask to have these records corrected. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about them by contacting the Office Manager.

- Patient agrees to release of medical or other information to process claim
- Patient agrees to accept assignment of payment
- Patient gave permission to leave a message on their answering machine or a text message on their cell
- Patient gave permission to discuss his medical condition with another person (your emergency contact)

Patient Consent and Financial Agreement

Please initial on the following lines

*_____I hearby authorize treatment by South Shore Dental. I understand that I am financially responsible for all charges incurred for services rendered regardless of litigation, insurance reimbursement, or pending labor & industry claims. I understand that the responsible party, or the parent accompanying a minor for any treatment will be responsible for payment. I authorize the release of any necessary information requested by my insurance company and/or attorney. I authorize payment directly to Dr. Matthew Lau, DDS.

*_____I understand that ALL co-payments and/or out of pocket payments are due on the day of treatment. We have a signed contract with most insurance companies that state we are to collect co-payment on the day of your scheduled appointment. It is the patient's responsibility to verify dental coverage and co-payments.

*_____I understand balances older than 180 days will be sent to a collection agency.

*_____I am committed to my health and attending my dental appointments. I understand in the event that I need to cancel or reschedule my appointment, I will provide South Shore Dental with a 48 hour notice in order to avoid a $50 fee, payable prior to my next visit.

*_____I understand, in the event I do not show up for my appointment all future appointments may be cancelled, until I call for a new appointment.

By my signature below, I acknowledge that I am aware of the Notice of Privacy Practices and authorize the above-mentioned release of information.

_____ _____

Print Name Date

_____ _____

Patient or Responsible Party Signature Relationship

Rev: 11/21/2017

Photograph Release

I _____, hearby authorize Dr. Matthew Lau or his assistants to take photographs, slides, and/or of my face, jaws, mouth, and teeth.

I understand that the photographs, slides, and/ or videos will be used as a record of my care, and maybe used for educational purposes in study club meetings, lectures, seminars, demonstrations, and professional publications (journals, magazines).

I further understand that if the photographs, slides, and/or videos are used in any publication or as a part of a demonstration, my name or other infentifying information will be kept confidential.

I do not expect compensation, financial or otherwise, for the use of these photgraphs.

Signature_____ Date_____