WELCOME

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have any questions we will be glad to help you. We look forward to working with you maintaining your dental health.

PATIENT INFORMATION:

Name:_____
Last *First* *Middle*

Home Phone: ( ) _____ Cell Phone: ( ) _____ Social Security #:_____
Date of Birth: _____

Address: _____ E-mail: _____
City: _____State:_____ Zip Code:_____
Sex: □ Male □ Female Age: _____Single □ Married □ Divorced □ Separated □ Widowed □

In case of an emergency, who should be notified: _____ Phone Number:_____
Name
Whom may we thank for referring you: _____

DENTAL INSURANCE/RESPONSIBLE PARTY:

Name of Insured _____

Relationship to patient:_____Birthdate:_____Social Security#_____
Address (*if different from patient*):_____Phone:_____
City:_____State:_____Zip Code:_____

Person Responsible Employed By:_____Occupation:_____
Business Address:_____Phone:_____

Insurance Company: _____Contact #: ( )_____Group #:_____ Subscriber #_____

MEDICAL HISTORY:

1. Are you in good health now?……...□ Yes □ No
2. Are you now under the care of a physician……□ Yes □ No
   If so, what is the condition being treated? _____Physician's Name:_____
   Address: _____Phone #:_____
3. Date of last medical examination_____
4. Have you ever been hospitalized or had a serious illness? ……..…….. □ Yes □ No
5. Have you had excessive bleeding requiring special treatment?……□ Yes □ No
6. Are you currently taking any medication?…… □ Yes □ No
   Please list name of medication, purpose, & dosage below:
   1. _____ 2._____ 3. _____
7. Are you **Allergic** or have you ever experienced any reaction to the following?
   Local Anesthetics (e.g. Novocain) ……□ Yes □ No
   Barbiturates/Sedatives/Sleeping Pills… □ Yes □ No
   Penicillin/Other antibiotics…… □ Yes □ No
   Aspirin……□ Yes □ No
   Codeine or other Narcotic…….. □ Yes □ No
   Sulfa Drugs…… □ Yes □ No
   Latex…… □ Yes □ No
   Other allergies?_____
8. (Women) Are you pregnant?…… □ Yes □ No If so, give due date_____
   Are you nursing? …… □ Yes □ No
   Are you taking Birth Control Pills? (Antibiotics may make birth control pills ineffective)…… □ Yes □ No

Swan Dental

9. Do you have or have you ever had any of the following?

Heart failure	☐ Yes	☐ No	Tumors or growths	☐ Yes	☐ No
Heart Disease	☐ Yes	☐ No	Cancer	☐ Yes	☐ No
Angina Pectoris	☐ Yes	☐ No	X-Ray or Cobalt Treatment	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No	Chemotherapy	☐ Yes	☐ No
Heart Murmur	☐ Yes	☐ No	Arthritis	☐ Yes	☐ No
Rheumatic Fever	☐ Yes	☐ No	Cortisone Medicine	☐ Yes	☐ No
Congenital Heart Lesions	☐ Yes	☐ No	Pain in Jaw Joints	☐ Yes	☐ No
Scarlet Fever	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No
Damaged or Artificial Heart Valves	☐ Yes	☐ No	Aids	☐ Yes	☐ No
Heart Pacemaker	☐ Yes	☐ No	Hepatitis A (Infectious)	☐ Yes	☐ No
Heart Surgery	☐ Yes	☐ No	Hepatitis B (Serum)	☐ Yes	☐ No
Artificial Joint	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Yellow Jaundice	☐ Yes	☐ No
Stroke	☐ Yes	☐ No	Blood Transfusion	☐ Yes	☐ No
Kidney Trouble	☐ Yes	☐ No	Drug Addiction	☐ Yes	☐ No
Ulcers	☐ Yes	☐ No	Hemophilia	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No	Venereal Disease (Syphilis, Gonorrhea)	☐ Yes	☐ No
Cough	☐ Yes	☐ No	Cold Sores	☐ Yes	☐ No
Tuberculosis (TB)	☐ Yes	☐ No	Epilepsy or Seizures	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Fainting or Dizzy Spells	☐ Yes	☐ No
Allergy, Hay fever, Sinus	☐ Yes	☐ No	Psychiatric Treatment	☐ Yes	☐ No
Metal Sensitivity	☐ Yes	☐ No	No Sickle Cell Disease	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Bruise Easily	☐ Yes	☐ No
Thyroid Disease	☐ Yes	☐ No			

10. Is there any disease, condition or problem not listed above that you think we should know about, or is there any activity your doctor said you cannot do? If so, explain:_____

DENTAL HISTORY

1. Reason for this visit? _____
2. Last dental visit? _____ Purpose _____ Last complete exam _____
3. Do you prefer local anesthetic (Novocain) for most dental treatment? ☐ Yes ☐ No
4. Have you ever had any serious trouble associated with previous dental treatment? _____
5. Does dental treatment make you nervous? ☐ No ☐ Slightly ☐ Moderately ☐ Extremely
6. Have you ever been treated for periodontal disease (Gum Disease, Pyorrhea, Trench Mouth)? ☐ Yes ☐ No
   If so, when? _____
7. Do you have or have you ever had the following?

Bleeding Sore Gums	☐ Yes	☐ No	Loose Teeth	☐ Yes	☐ No
Unpleasant Taste/Bad Breath	☐ Yes	☐ No	Sensitive to Hot	☐ Yes	☐ No
Burning Tongue/Lips	☐ Yes	☐ No	Sensitive to Cold	☐ Yes	☐ No
Frequent Blisters, Lips, Mouth	☐ Yes	☐ No	Sensitive to Sweets	☐ Yes	☐ No
Swelling/Lumps in Mouth	☐ Yes	☐ No	Sensitive to Biting	☐ Yes	☐ No
Ortho Treatment (Braces)	☐ Yes	☐ No	Food Impaction	☐ Yes	☐ No
Biting Cheeks/ Lips	☐ Yes	☐ No	Clenching/Grinding	☐ Yes	☐ No
Clicking/Popping Jaw	☐ Yes	☐ No	Complications from Extractions	☐ Yes	☐ No
Difficulty Opening or Closing Jaw	☐ Yes	☐ No	Cigarettes, Pipe, and Cigar Smoking	☐ Yes	☐ No

Preferred Method of Payment: ☐ **Cash** ☐ **Check** ☐ **Credit Card (Mastercard, Visa, Care Credit)**

There is a minimum $20.00 charge for all returned checks.

Appointments: A minimum charge will be made for failed or cancelled appointment without prior notification of 24 hours. Once an appointment is made, please remember this time has been reserved for you.

I have completed this form fully and completely, and certify that I am the patient or duly authorized general agent of the patient authorized to furnish the information requested. I understand that even though I have some type of insurance coverage, I am responsible for payment of services.

Signature (Parent or Guardian, if Patient is a minor):_____ Date: _____

Dentist's Signature: _____ Date: _____