Swearingensmiles
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PATIENT INFORMATION				
First Name:	Middle:	Last Name:	Date of Birth:	Age:
Gender:	SSN:		Marital Status:	
Mailing Address Line:		City:	State:	Zip:
Home Phone:	**Cell Phone:**		Work Phone:	
Email Address:		Occupation:		
Employer:			Phone:	
Employer Address Line:		Employer City:	State:	Zip:

PREFERRED METHOLD OF COMMUNICATION
WHAT IS THE BEST WAY TO CONTACT YOU: Home phone [ ] Cell phone [ ] Cell phone TEXT [ ] Work phone [ ] Email [ ]

SPOUSE / GUARDIAN / SIGNIFICANT OTHER				
First Name:	Middle Initial:	Last Name:		SSN:
Address:	City:	State:	Zip:	Date of Birth:
Home Phone:	Cell Phone:	Employer:		Phone:
Employer Address:		Employer City:	Employer State:	Zip:

PERSON TO CONTACT IN CASE OF EMERGENCY		
Contact Relationship:	First Name:	Last Name:
Home Phone:	Cell Phone:	Employer Phone:

Nearest relative or friend not living with you

Name	Relationship	Daytime Phone

Do you authorize this office to discuss your care or treatment with any party besides yourself: [ ] Yes [ ] No

Authorized Persons (if any):

DENTAL INSURANCE INFORMATION				
Dental Insurance Type				
Primary insurance:		Policy Number:		Phone Number:
Policy holder's Name:		Date of Birth:		Home Phone:
Address:	City:	State:	Zip:	Group Number:
Secondary Insurance:		Policy Number:		Phone Number:
Policy holder's Name:		Date of Birth:		Home Phone:
Address:	City:	State:	Zip:	Group Number:

I have no Dental Insurance [ ]

ACCOUNT INFORMATION				
Person Responsible For This Account:		Birth Date:	SS #:	Cell Phone:
First Name	Middle:	Last Name:		Home Phone:
Drivers License #:	State:	Occupation:		Work Phone:
Employer:	Business Address:		City:	State: Zip:
Home Address:		City:	State:	Zip:

FINANCIAL RESPONSIBILITY

Person Financially Responsible for Balance Not Covered by Insurance: [ ] Patient [ ] Spouse [ ] Parent [ ] Guardian

Payment in full is expected at each appointment. For your convenience, we offer the following methods of payment. Please check the option that you prefer, If you have any questions concerning financial arrangements, it will be our pleasure to assist you.

Cash [ ] Personal Check [ ] MasterCard [ ] Visa [ ] Care Credit [ ]

MEDICAL HEALTH HISTORY

Although dental professionals primarily treat the area in and around the mouth, your mouth is a part of your entire body. Health problems you may have or medications you may be taking could impact your oral health and may have an important interrelationship with the dentistry you will receive.

Thank you for answering the following questions:

Do you have or have you had any of the following? Please circle all that apply. If necessary, use back of form to explain.

AIDS/HIV
Alzheimer's/Dementia
Anaphylaxis
Anemia
Angina
Arthritis/Gout
Artificial Heart Valve
Artificial Joint
Asthma
Back Problems
Blood Disease
Blood Transfusion
Bisphosphonate Therapy
(For Osteoporosis)
Breathing Problems
Cancer
Chemotherapy
Chest Pain
Circulatory Problems
Cold Sores/Fever Blisters
Congenital Heart Disorder
Diabetes
Dizziness
Emphysema
Epilepsy/Seizures
Excessive bleeding
Fainting Spells
Frequent Headaches
Genital Herpes
Hay Fever/Allergies-
Heart Attack/Failure
Heart Murmur
Heart Pace Maker
Hemophilia
Hepatitis A
Hepatitis B
Hepatitis C
Herpes
High Blood Pressure
Hives or Rash
Hypoglycemia
Irregular Heart Beat
Kidney Problems/Disease
Leukemia
Liver Disease
Low Blood Pressure
Lung Disease
Mitral Valve Prolapse
Migraine Headaches
Osteoporosis
Osteopenia
Pain in Jaw Joint
Parathyroid Disease
Psychiatric Care
Radiation Therapy
Respiratory Disease
Renal Dialysis
Rheumatic Fever
Scarlet Fever
Shingles
Sickle Cell Disease
Sinus Problems
Skin Disorders
Sleep Apnea
GI Disorders
Stroke
Swelling of Limbs/Edema
Thyroid Disease
(Hyperthyroid/ Hypothyroid)
Tuberculosis
Tumors or Growths
Ulcers
Venereal Disease

HISTORY OF HOSPITALIZATIONS AND SURGERIES

Type	Year	Type	Year

ALLERGIES

Are you allergic to or have you had any reaction to any of the following?

□ Aspirin □ Pencillin □ Codiene □ Acrylic □ Metal □ Sulfa Drugs or Antibiotics
□ Local Anesthetics □ Latex □ Sedatives □ Iodine □ Narcotics □ Sleeping Pills
□ Barbiturates or Benzodiazepines (Insomnia, Anxiety), Anticonvulsants (Seizures, Epilepsy)
□ OTHER Allerigies or sensitivities not listed above: _____
If you checked YES to any of the above, please explain:

Allergy to	Reaction Type	Allergy to	Reaction Type

MEDICATIONS AND SUPPLEMENTS

Medication / Supplement Name:	Medication / Supplement Name:

Please answer the following:	Yes	No	If YES, please EXPLAIN (use back of form if additional space is required) .
1.Are you under the care of a physicians care now?	□	□	_____
2. Have you ever had a serious head or neck injury?	□	□	_____
3. Do you take blood thinning medications?(Coumadin,Plavix)	□	□	_____
4. Do you use tobacco?	□	□	_____
5. Do you use controlled substances?	□	□	_____

WOMEN ONLY

Are you or could you be pregnant: [ ] Yes [ ] No	Late Period: [ ] Yes [ ] No
Are you breast feeding: [ ] Yes [ ] No	Do you take birth control medication: [ ] Yes [ ] No

DENTAL HEALTH HISTORY

Date of last dental visit:		What was done at that visit?:	
Name of previous Dentist:	City:	State:	Phone:
Why did you leave your previous dentist?			
Last oral cancer screening:	Last cleaning:	Last complete X-Rays:	
What is the most important thing to you about your future smile and dental health?			
What is the most important thing to you about your dental visit today?			

Do your gums bleed while brushing/ flossing: [ ] Yes [ ] No	Have you ever had any difficult extractions [ ] Yes [ ] No
Do you feel pain in any of your teeth: [ ] Yes [ ] No	Any prolonged bleeding following extractions: [ ] Yes [ ] No
Have you had any head, neck or jaw injuries: [ ] Yes [ ] No	Are your teeth sensitive to hot or cold liquids/foods: [ ] Yes [ ] No
Have you had any orthodontic treatment: [ ] Yes [ ] No	Do you have any sore/lumps in or near your mouth: [ ] Yes [ ] No
Do you wear dentures or partials: [ ] Yes [ ] No	Have you ever experienced any jaw joint problems: [ ] Yes [ ] No
Do you have frequent headaches: [ ] Yes [ ] No	Have you ever received oral hygiene instructions: [ ] Yes [ ] No
Do you clench or grind your teeth: [ ] Yes [ ] No	Do you smoke or use chewing tobacco: [ ] Yes [ ] No How much:
Do you bite your lips or cheeks frequently: [ ] Yes [ ] No	Do you like your smile: [ ] Yes [ ] No

ON A SCALE OF 1 TO 10, WITH 10 BEING THE HIGHEST, PLEASE RATE THE FOLLOWING: Where would you rate your current dental health:	
How important is your dental health to you:	Where would you rate your current dental health:
Where do you want your dental health to be:	

IF I COULD CHANGE MY SMILE, I WOULD:					
Make it whiter:	[ ] Yes [ ] No	Close spaces:	[ ] Yes [ ] No	Make it straighter:	[ ] Yes [ ] No
Replace black metal fillings with tooth colored restorations:	[ ] Yes [ ] No			Repair chipped teeth:	[ ] Yes [ ] No
Replace old crowns that don't match:	[ ] Yes [ ] No			Have a smile makeover:	[ ] Yes [ ] No
If you could whiten your teeth would you do it:	[ ] Yes [ ] No			Replace missing teeth:	[ ] Yes [ ] No

Are you experiencing any dental problems now: [ ] Yes [ ] No	If yes please describe:

GENERAL DENTAL HISTORY:

1. Have you had:
   - Regular preventive dental care? [ ] Yes [ ] No
   - Gum treatment? [ ] Yes [ ] No
   - Oral surgery treatment? [ ] Yes [ ] No
   - Bite (occlusion) treatment? [ ] Yes [ ] No
   - Orthodontic care (braces)? [ ] Yes [ ] No
   - Root canal treatment? [ ] Yes [ ] No
   - Dentures or bridgework? [ ] Yes [ ] No
2. Do you now have:
   - A bite problem? [ ] Yes [ ] No
   - Bleeding gums? [ ] Yes [ ] No
   - Gum pain or swelling? [ ] Yes [ ] No
   - Food catching between teeth? [ ] Yes [ ] No
   - Any sensitive teeth? [ ] Yes [ ] No
   - Any toothaches? [ ] Yes [ ] No
   - Bad breath? [ ] Yes [ ] No
   - Loose or moving teeth? [ ] Yes [ ] No
   - Dry mouth problems? [ ] Yes [ ] No
   - White areas in mouth? [ ] Yes [ ] No
   - Frequent cold sores or mouth sores/ulcers? [ ] Yes [ ] No
3. Can you:
   - Chew your food effectively? [ ] Yes [ ] No
   - Talk and smile without worrying about your teeth? [ ] Yes [ ] No
   - Bite without pain? [ ] Yes [ ] No
4. Do you/your:
   - Brush your teeth daily? [ ] Yes [ ] No
   - Floss your teeth daily? [ ] Yes [ ] No
   - Clean your teeth in other ways? [ ] Yes [ ] No
   - Use a fluoride treatment? [ ] Yes [ ] No
   - Use mouthwash? [ ] Yes [ ] No
   - Form tarter quickly? [ ] Yes [ ] No
   - Use a water pick? [ ] Yes [ ] No
   - Grind or clench your teeth? [ ] Yes [ ] No
   - Have a concern over losing your teeth? [ ] Yes [ ] No
   - Chew mostly on one side? [ ] Yes [ ] No
   - Eat a lot of sweets/sugary foods? [ ] Yes [ ] No
   - Teeth interfere with your speech? [ ] Yes [ ] No
   - Like the appearance of your smile? [ ] Yes [ ] No
   - Like the color of your teeth? [ ] Yes [ ] No
   - Teeth break or fracture easily? [ ] Yes [ ] No
   - Wear a retainer, mouth appliance, brux splint or mouth guard? [ ] Yes [ ] No
5. Do you or have you ever experienced:
   - Difficulty opening or closing your jaw/mouth? [ ] Yes [ ] No
   - Difficulty chewing? [ ] Yes [ ] No
   - Pain or discomfort in your jaw? [ ] Yes [ ] No
   - Clicking or popping of your jaw? [ ] Yes [ ] No
   - Pain in or around your ear or the side of your face? [ ] Yes [ ] No
   - Jaw muscle tiredness or soreness? [ ] Yes [ ] No

PHARMACY INFORMATION

Pharmacy name:	Address:	Phone:

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

NAME _____ DATE _____

HOW DID YOU HEAR ABOUT OUR OFFICE? IS THERE SOMEONE WE SHOULD THANK FOR REFERRING YOU?			
TV Commercial [ ]	Billboard [ ]	Yellow Pages [ ]	Our Web Site [ ]
Mobile App [ ]	Internet Search [ ]	Face Book [ ]	Other Social Media [ ]
Friend [ ]	Patient [ ]	Doctor [ ]	Friend [ ]