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Thank you for trusting us with your dental care. We promise to do our best to provide you with the finest care available. If you have any questions please do not hesitate to call us at the number above.

DATE __ __ / __ __ / __ __ __ __

Patient Information

Name________________________ Birthdate ______________ Social Security # ______- _____- _______

Address ________________________ City________________ State _______ Zip ______________

Sex/Marital Status ❑ Male ❑ Female | ❑ Married ❑ Widowed ❑ Single ❑ Minor ❑ Separated ❑ Divorced ❑ Partnered for ___ years

E-mail ________________________ Home phone (_______) ________ Cell phone (_______) ____________

Employer/School ________________________ Employer/School Phone (_______) ________________

Employer/School Address ________________________ City________________ State _______ Zip ______________

Spouse or Parent's Name ________________________ Employer ______________ Work Phone (_______) ____________

Whom may we thank for referring you? ____

Person to contact in case of emergency ________________________________ Phone (_______)______________

Responsible Party

Name of Person Responsible for this Account ____________________ Relationship to Patient ____________________

Address ________________________________ Home Phone (_______) ____________________

Driver's License # ________________________________ Birthdate ______________ Bank ______________

Employer________________________________ Work Phone (_______) ____________________

Currently a Patient in our office? ❑ Yes ❑ No Email________________________Cell Phone (_______)______________

Insurance Information

Name of Insured ________________________ Relationship to Patient ________________________

Birthdate________________________ Social Security # ______________ Date Employed ________________

Employer________________________ Work Phone(_______) ________________________

Employer Address ________________________ City________________ State _______ Zip ______________

Insurance Company ________________________ Group # ______________ Union or Local # ______________

Insurance Address ________________________ City________________ State _______ Zip ______________

How much is your deductible?______________How much have you used? ______________ Maximum Annual Benefit ___________

Authorization & Release

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health. I certify that I, and/or my dependent(s), have insurance coverage with (company)________________________________ and assign directly to Swords & Phelps Dentistry all insurance benefits if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. Swords & Phelps Dentistry may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when the current treatment plan is completed or one year from the date signed below.

Signature of Patient, Parent, Guardian or Personal Representative

________________________________ Date ________________________

Printed Name of Patient, Parent, Guardian or Personal Representative

________________________________ Relationship to Patient________________________

PAYMENT IS DUE IN FULL AT TIME OF TREATMENT UNLESS PRIOR ARRANGEMENTS HAVE BEEN APPROVED.

Dental History

Reason for today's visit________________________________ Date of last dental care________________________________
Former Dentist ________________________________ Date of last dental x-rays ________________________________
Address ____

Check (√) if you have had problems with any of the following:

- ❑ Bad breath
- ❑ Bleeding gums
- ❑ Clicking or popping jaw
- ❑ Food collection between the teeth
- ❑ Grinding Teeth
- ❑ Loose teeth or broken fillings
- ❑ Periodontal treatment
- ❑ Sensitivity to cold
- ❑ Sensitivity to hot
- ❑ Sensitivity to sweets
- ❑ Sensitivity when biting
- ❑ Sores or growths in your mouth

How often do you floss?________________________________ How often do you brush? ________________________________

Medical History

Physician's Names and specialty ____
(Please include primary care, and any other providers - OB/Gyn, Pain Management, Cardiology, Orthopedic, ENT, etc.)
____
____

Have you had any serious illnesses or diseases? ❑ Yes ❑ No If yes, describe________________________________
Past surgical history (cardiac, abdominal, orthopedic, etc) ________________________________
____

Check (√) if you have had problems with any of the following:

- ❑ **Arthritis, Rheumatism**
- ❑ **Artificial joint/replacement**
- ❑ **Asthma**
- ❑ **Back Problems**
- ❑ **Brittle bones / osteoporosis treatment**
  - ❑ Biosphosphate usage
  (circle and indicate time frame)

GENERIC	BRANDED
alendronate	Fosamax
Ibandronate	Boniva
risedronate	Actonel/Atelvia
zoledronic acid	Reclast

- ❑ **Bleeding disorder / disease?**
  - ❑ Anemia
  - ❑ Hemophilia
  - ❑ Leukemia
  - ❑ Other
- ❑ **Blood thinner?**
  (circle and indicate time frame)

GENERIC	BRANDED
Aspirin 81mg	-
Aspirin 325mg	-
clopidogrel	Plavix
warfarin	Coumadin
apixaban	Eliquis
dabigatran	Pradaxa
edoxaban	Savaysa
rivaroxaban	Xarelto

- ❑ **Cancer**________________________
  List dates and types of treatment
  (chemo, radiation, surgical resection)
  ____
  ____
- ❑ **Cardiac disease** (please check)
  - ❑ Angina
  - ❑ Arteriosclerosis
  - ❑ Artificial heart valve
  - ❑ Bacteremia
  - ❑ Bypass
  - ❑ Coronary artery disease
  - ❑ Congenital heart defects
  - ❑ Heart attack
  - ❑ Heart murmur
  - ❑ High blood pressure
  - ❑ Low blood pressure
  - ❑ Mitral valve prolapse
  - ❑ Pacemaker placement
  - ❑ Stent placement
  - ❑ Stroke
  - ❑ Swelling of feet/ankles?
- ❑ **Chemical dependency**
- ❑ **Cortisone treatments**
- ❑ **Diabetes** (please indicate)
  ❑ Type 1 ❑ Type 2
- ❑ **Dry mouth?** (Sjögren's syndrome)
- ❑ **Epilepsy**
- ❑ **Fainting**
- ❑ **Glaucoma**
- ❑ **Headaches / migraines**
- ❑ **Hernia repair**
- ❑ **HIV / AIDS**
- ❑ **Jaw pain / previous TMD treatment?**
- ❑ **Kidney disease**
- ❑ **Liver disease**
  - ❑ Hepatitis (Type_______)
  - ❑ Jaundice
- ❑ **Lung problems**
  - ❑ COPD
  - ❑ Cough, persistant
  - ❑ Coughing blood (hemoptysis)
  - ❑ Emphysema
  - ❑ Respiratory disease
- ❑ **Mental health treatment?**
  - ❑ Anxiety
  - ❑ Depression
- ❑ **Radiation**
  (please indicate type and location)
  ____
  ____
- ❑ **Rheumatic fever**
- ❑ **Scarlet fever**
- ❑ **Shortness of breath**
- ❑ **Sinus problems**
- ❑ **Skin rash**
- ❑ **Sleep apnea**
  - ❑ Have you had a sleep study or been recommended for one?
  - ❑ Have you been told you snore?
  - ❑ Do you wear a C-PAP?
- ❑ **Thyroid problems**
- ❑ **Tobacco habit**
  (please check & indicate amount of usage)
  - ❑ Smoke____________________
  - ❑ Dip____________________
- ❑ **Tonsillitis**
- ❑ **Tuberculosis**
- ❑ **Ulcer**
  (stomach, esophageal, abdominal, etc)
  - ❑ Diagnosed with GERD?
  - ❑ Do you have acid reflux or frequent heartburn?
- ❑ **Venereal disease**
- ❑ Please list any other diagnosed medical problems or conditions
  ____
  ____
  ____
  ____

Please list the medication you are currently taking... and the correlating diagnosis:
________________________________ ________________________________
________________________________ ________________________________

Please list non-prescription medications.
____
____

Please list any allergies:
____
____