Thank you for choosing our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us – we will be happy to help.

Today's Date: ____________________

Patient's Name: ______________________________ ☐ Male ☐ Female

Date of Birth: ______________ Age: ________ Single / Married / Separated / Widowed

Home Phone: ____________ Cell Phone: ____________ Work Phone: ____________

Home address: ____

____

Social Security #: _____/_____/______ Driver's License #: ____________________

If Patient is a Minor: Mother's Birth Date: _____/_____ /_____ Father's Birth Date: _____/_____/_____

Are you a full time student? Yes / No

Person Responsible for Account: ______________________________

Name of Spouse (Parent if Minor): ______________________________

Spouse's Date of Birth: ______________ Employer's Name: ______________

Spouse's Social Security #: ______________ Work Phone: ______________

Emergency Info (Name, Address & Telephone# of a relative not living with you): ______________

____

Insurance Company: ______________ Insurance Ph#: ______________

Insurance Id#: ______________ Group#: ______________

How did you hear about our office? ______________________________

MEDICAL HEALTH HISTORY

PATIENT NAME: ______________________

A. CIRCLE YOUR ANSWERS (leave BLANK if you do not understand the question):

1. Yes No Are you in good health?
2. Yes No Has there been a change in your health within the last year? Explain: ______________________
3. Yes No Have you been hospitalized or had a serious illness in the last 5 years? Explain: ______________________
4. Yes No Are you being treated by a physician now? For what? ______________________

Name of your physician: ______________________ Date of last Medical Exam: ______________________

B. HAVE YOU EVER EXPERIENCED?

5. Yes No Chest Pains
6. Yes No Swollen Ankles
7. Yes No Shortness of breath
8. Yes No Recent weight loss, fever, night sweats
9. Yes No Persistent cough, coughing up blood
10. Yes No Bleeding problems, bruising easily
11. Yes No Sinus Problems
12. Yes No Difficulty swallowing
13. Yes No Diarrhea, constipation, blood in stools
14. Yes No Frequent vomiting, nausea
15. Yes No Difficulty urinating, blood in urine
16. Yes No Dizziness
17. Yes No Ringing in ears
18. Yes No Frequent Headaches
19. Yes No Fainting spells
20. Yes No Blurred Vision
21. Yes No Seizures
22. Yes No Excessive thirst
23. Yes No Frequent urination
24. Yes No Dry Mouth
25. Yes No Jaundice
26. Yes No Joint pain, stiffness
27. Yes No Sleep apnea or chronic snoring

C. DO YOU HAVE OR HAVE YOU HAD:

28. Yes No Heart disease
29. Yes No Heart attack, heart defects
30. Yes No Heart murmur
31. Yes No Rheumatic fever
32. Yes No Stroke, hardening of arteries
33. Yes No High Blood Pressure
34. Yes No TB, emphysema or other lung diseases
35. Yes No Hepatitis, A B C
36. Yes No Stomach problems, ulcers
37. Yes No Diabetes
38. Yes No Family History of diabetes, heart problems, cancer
39. Yes No HIV positive or AIDS-ARC
40. Yes No Tumors, Cancer
41. Yes No Arthritis, rheumatism
42. Yes No Eye disease
43. Yes No Skin disease
44. Yes No Anemia
45. Yes No VD (syphilis or gonorrhea)
46. Yes No Herpes
47. Yes No Kidney, bladder diseases
48. Yes No Thyroid, adrenal diseases
49. **ALLERGIES**: to drugs, food, medications, metals, jewelry, acrylics; **list the following allergies:** ______________________

____

D. DO YOU HAVE OR HAVE YOU HAD:

50. Yes No Surgeries ______________________
51. Yes No Blood Transfusions ______________________
52. Yes No Artificial Joint ______________________
53. Yes No Contact Lenses ______________________
54. Yes No Psychiatric Care ______________________
55. Yes No Radiation Treatments
56. Yes No Chemotherapy
57. Yes No Prosthetic heart valve
58. Yes No Pacemaker
59. Yes No **Women only**: Birth Control Pills
60. Yes No **Women only: Pregnant or nursing**

E. DO YOU TAKE OR HAVE TAKEN:

61. Yes No Recreational drugs
62. Yes No Alcohol
63. Yes No Tobacco in any forms
64. Yes No Phen Phen diet Pills or any other diet pills

VITAMINS & MEDICATIONS: ______________________

____

____

F. ALL PATIENTS:

65. Yes No Do you have or have you had any other diseases or medical problems NOT listed on this form? If so, please explain:

____

66. Yes No Have you ever been told by a physician or dentist that you need to pre-medicated prior to any dental treatment?

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SWANSON DENTAL GROUP

DR. CHRISTY SWANSON DMD

DENTAL TREATMENT AND FINANCIAL RESPONSIBILTY

A Treatment Plan will be prepared for you detaining you or your family's specific dental needs as well as the related estimated costs of that treatment. Swanson Dental Group is a fee for service dental office and payment or insurance co-payments are due as services are rendered. We are sensitive to the fact that some patients may require alternative payment options, and therefore, we accept the following:

Cash or Check

Visa, MasterCard or Discover Card

All returned checks are subject to a $25.00 charge.

REGARDING DENTAL INSURANCE

There are many types of dental insurance. Some of them are considered great to work with and allow the dentist to decide which treatment options are best for you or your family. Others are very difficult to deal with and ask the dentist to make compromises in her care, thus preventing the dentist from providing the highest quality of dental care for you or your family. This office is not willing to allow insurance companies to influence our standard or care, so there are insurances that we are willing to bill for our patients and there are others we will not. If you have dental insurance, whether it is one we will bill or one we will not, our team is able to help you optimize your insurance benefits. We ask that you pay any deductible and estimated patient portion for all covered and non-covered services as they are rendered. Please utilize one of the payment options listed above.

Please be aware that we are only able to estimate what your insurance coverage may be, and that the actual patient portion may be more than expected. The responsible party is still responsible for the entire amount. All balances which remain over 45 days are subject to a 1.5% monthly finance charge.

AUTHORIZATION TO BILL

I authorize Dr. Christy Swanson to forward a review of findings and/or any other dental information to the referring doctor (if such has been the referral source) or any other health care giver for his/her records, as well as any third parties such as insurance companies who may request information. I agree if insurance is billed, that Dr. Swanson will collect the payment.

APPOINTMENTS

Appointment times are reserved especially for you. If you must change your appointment time, we ask that you please notify us immediately. If a pattern of late cancellations or no-show develops, you may be subject to a $25.00 room set up charge for each missed appointment.

____ ________________

Signature of Responsible Party / Parent Date

Swanson Dental

Notice of Privacy Practices
Patient Acknowledgement

Patient Name: ________________________________
Date of Birth: ________________________________

I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides in dental the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information.

I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices, and to make changes regarding all protected health information resident at, or controlled by, this practice. I understand I can obtain this practice's current Notice of Privacy Practices on request.

Signature: ________________________________
Date: ________________________________