## *Welcome to Swanson Dental*

Thank you for trusting us with your dental needs. We are committed to providing the finest care available. If you have any questions, please do not hesitate to ask.

### Patient information

Name _____ Birthday ___/____/____ SSN# _____-____-_____
Address_____ City _____ St ____ Zip _____
Home Phone (  ) _____ Cell Phone (  ) _____
Check Appropriate: □ Minor □ Single □ Married □ Male □ Female
Patient's Employer or School _____
Work Phone (  ) _____ Are we able to contact you at work? □ Yes □ No
Emergency Contact:_____ Relationship _____
Phone (  ) _____

Email: _____
Preferred method for appointment reminders? □ Email □ Text □ Phone call/Post cards

How did you hear about our office (Yellow Pages, Google, Insurance)? _____
Or whom may we thank for referring you? _____

### Responsible Party □ Check here if same as patient

Name_____ Relationship to patient _____
Address_____ City_____ St___ Zip_____
Home Phone (  ) _____ Cell Phone (  ) _____
DOB ___/____/_____ SSN# _____-_____-_____

### Primary Dental Insurance □ Check here if no insurance

Insurance Co. Name _____ Phone (  ) _____
Insurance Co. Address_____ City _____ St ____ Zip _____
Employer_____ ID#_____ Group # (Plan or Local)_____

□ Check here if insured is same as Responsible Party, or
Insured's Name _____ Relationship to patient _____
Insured's DOB ___/____/_____ SSN# _____-_____-_____ Phone (  ) _____

### Secondary Dental Insurance □ Check here if no secondary insurance

Insurance Co. Name_____ Phone (  )_____
Insurance Co. Address_____ City_____ St_____ Zip_____
Employer _____ID#_____ Group # (Plan or Local)_____

□ Check here if same as Responsible Party □ Check here if same as Primary Insurance Holder, or
Insured's Name_____ Relationship to patient _____
Insured's DOB ___/____/_____ SSN# _____-_____-_____ Phone (  ) _____

## Dental History

Reason for today's visit_____

Previous Dentist _____ Date of last visit/x-rays_____

How often do you brush?_____ How often do you floss?_____

**Check if you are concerned with any of the following:**

| | | |
|---|---|---|
| □ Lost or broken fillings | □ Bad breath | □ Sensitivity to hot/cold |
| □ Missing teeth | □ Bleeding gums | □ Sensitivity to sweets |
| □ Food collection between teeth | □ Periodontal treatment | □ Sensitivity when chewing |
| □ Popping or clicking of the jaw | □ Dry Mouth | □ Sores/growths in the mouth |
| | | □ Pain |

## Medical History

Physician's name_____ Date of last visit_____

Are you in good health? □ Yes □ No Are you currently under the care of a physician? □ Yes □ No

If yes, please explain _____

Do you use tobacco? □ Yes □ No

Do you have a history of alcohol or chemical dependency? □ Yes □ No

**For women only:**

Are you pregnant (or think you might be)? □ Yes □ No Taking oral contraceptives? □ Yes □ No

Are you nursing? □ Yes □ No

**Are you allergic to or have you had an adverse reaction to:**

□ Local anesthetic □ Codeine/Narcotics □ Penicillin □ Latex □ Aspirin/Ibuprofen

□ Sulfa □ Acrylic □ Metal □ Other _____

**Are you using any of the following?**

| | | |
|---|---|---|
| □ Antibiotics | □ Anticoagulants (blood thinners) | □ Aspirin, Aleve, Ibuprofen, Tylenol |
| □ High blood pressure medication | □ Steroids (Cortisone, etc.) | □ Nitroglycerin, Digoxin, Inderal |
| □ Insulin or oral anti-diabetic drugs | □ Other _____ | |

**Please check any condition below that you have a known history with.**

| | | | |
|---|---|---|---|
| ☐ Anemia | ☐ Angina | ☐ Arthritis | ☐ Artificial Heart Valve |
| ☐ Artificial Joints | ☐ Asthma | ☐ Blood Disease | ☐ Blood Transfusion |
| ☐ Breathing issues | ☐ Cancer | ☐ Chemotherapy | ☐ Cold Sores/Fever Blisters |
| ☐ Diabetes | ☐ Emphysema | ☐ Epilepsy or Seizures | ☐ Excessive Bleeding |
| ☐ Fainting/Dizziness | ☐ Heart Attack | ☐ Heart Murmur | ☐ Congenital Heart Disease |
| ☐ Heart Pacemaker | ☐ Heart Disease | ☐ Hemophilia | ☐ Hepatitis A |
| ☐ Hepatitis B or C | ☐ Herpes | ☐ High Blood Pressure | ☐ Kidney disease |
| ☐ Liver Disease | ☐ Low Blood Pressure | ☐ Lung Disease | ☐ Mitral Valve Prolapse |
| ☐ Psychiatric Care | ☐ Radiation | ☐ Shingles | ☐ Sinus Trouble |
| ☐ Stroke | ☐ Thyroid Disease | ☐ Tuberculosis | ☐ Tumors or Growths |

☐ Other/Comments _____

_____

_____

**I have read and answered the above questions to the best of my knowledge. I will not hold Swanson Family Dental PC or any member of the staff responsible for any errors or omissions that I may have made in the completion of this form. I authorize and request my insurance company pay directly to Swanson Family Dental PC insurance benefits otherwise payable to me. I authorize the doctor to release all information necessary to secure the payment benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of this signature on all insurance submissions.**

Patient Signature_____ Date _____

Health History has been reviewed by _____ Date _____