SOUTH WESTERN DENTAL

PATIENT INFORMATION DATE_____

PATIENT_____ ___ ___ BIRTHDATE_____ SOC. SEC. #_____
FIRST MI LAST M F

ADDRESS_____ CITY_____ STATE_____ ZIP_____

HOME PHONE _____ CELL _____ EMAIL_____

COMMUNICATION PREFERENCES - CHECK ALL THAT APPLY: TEXT MESSAGES ____ EMAILS ____ PHONE CALLS ____

CHECK APPROPRIATE: ____MINOR ____SINGLE ____MARRIED ____DIVORCED ____WIDOWED ____SEPARATED

PATIENT'S EMPLOYER_____ WORK PHONE_____

PERSON TO CONTACT IN CASE OF AN EMERGENCY_____ PHONE(S) _____

HOW DID YOU HEAR ABOUT US?_____

SPOUSE OR PARENT'S NAME_____ SPOUSE'S EMPLOYER _____ SPOUSE'S WORK PHONE_____

RESPONSIBLE PARTY

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT_____ RELATIONSHIP TO PATIENT_____

ADDRESS_____ CITY_____ STATE_____ ZIP_____

HOME PHONE _____ CELL PHONE_____ BIRTHDATE_____ SOC. SEC. #_____

NAME OF EMPLOYER_____ WORK PHONE _____

DO YOU HAVE DENTAL INSURANCE? ____ YES ____ NO **IF YES, COMPLETE THE FOLLOWING:**

FAMILY COVERAGE ____ OR SINGLE COVERAGE ____

POLICYHOLDER_____ RELATIONSHIP TO PATIENT_____

POLICYHOLDER'S ADDRESS: _____

BIRTHDATE_____ SOC. SEC. #_____ NAME OF EMPLOYER_____ WORK PHONE _____

INSURANCE COMPANY_____ ID# _____ GROUP#_____

DO YOU HAVE ANY ADDITIONAL DENTAL INSURANCE? ____ YES ____ NO **IF YES, COMPLETE THE FOLLOWING:**

FAMILY COVERAGE ____ OR SINGLE COVERAGE ____

POLICYHOLDER_____ RELATIONSHIP TO PATIENT_____

POLICYHOLDER'S ADDRESS: _____

BIRTHDATE_____ SOC. SEC. #_____ NAME OF EMPLOYER_____ WORK PHONE _____

INSURANCE COMPANY_____ ID# _____ GROUP#_____

We ask that your fees be paid at each appointment. We accept cash, personal checks, money orders, VISA, MC, and Discover. Please advise our business staff if you would like to apply for outside financing. Charges not paid within 60 days will have a service charge of 1.5% per month (Annual Rate of 18%)

_____

SIGNATURE

PLEASE COMPLETE BACK SIDE OF THIS FORM ALSO (OVER)

SOUTH WESTERN DENTAL

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

INJURIES / MEDICATIONS / ALLERGIES

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: _____

Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____

Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____

Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____

Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No _____

Are you on a special diet? ◯ Yes ◯ No

Do you use tobacco? ◯ Yes ◯ No

Women: Are you ☐ Pregnant or trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics ☐ Sulfa Drugs

☐ Other If yes, please explain: _____

Do you use controlled substances? ◯ Yes ◯ No

ILLNESSES / CONDITIONS

Do you have, or have you had, any of the following?

☐ AIDS/HIV Positive	☐ Chest Pains	☐ Frequent Headaches	☐ Hypoglycemia	☐ Rheumatic Fever
☐ Alzheimer's Disease	☐ Cold Sores/Fever Blisters	☐ Genital Herpes	☐ Irregular Heartbeat	☐ Rheumatism
☐ Anaphylaxis	☐ Congenital Heart Disorder	☐ Glaucoma	☐ Kidney Problems	☐ Scarlet Fever
☐ Anemia	☐ Convulsions	☐ Hay Fever	☐ Leukemia	☐ Shingles
☐ Angina	☐ Cortisone Medicine	☐ Heart Attack/Failure	☐ Liver Disease	☐ Sickle Cell Disease
☐ Arthritis/Gout	☐ Diabetes	☐ Heart Murmur	☐ Low Blood Pressure	☐ Sinus Trouble
☐ Artificial Heart Valve	☐ Drug Addiction	☐ Heart Pacemaker	☐ Lung Disease	☐ Spina Bifida
☐ Artificial Joint	☐ Easily Winded	☐ Heart Trouble/Disease	☐ Mitral Valve Prolapse	☐ Stomach/Intestinal Disease
☐ Asthma	☐ Emphysema	☐ Hemophilia	☐ Osteoporosis	☐ Stroke
☐ Blood Disease	☐ Epilepsy or Seizures	☐ Hepatitis A	☐ Pain in Jaw Joints	☐ Swelling of Limbs
☐ Blood Transfusion	☐ Excessive Bleeding	☐ Hepatitis B or C	☐ Parathyroid Disease	☐ Thyroid Disease
☐ Breathing Problem	☐ Excessive Thirst	☐ Herpes	☐ Psychiatric Care	☐ Tonsillitis
☐ Bruise Easily	☐ Fainting Spells/Dizziness	☐ High Blood Pressure	☐ Radiation Treatments	☐ Tuberculosis
☐ Cancer	☐ Frequent Cough	☐ High Cholesterol	☐ Recent Weight Loss	☐ Tumors or Growths
☐ Chemotherapy	☐ Frequent Diarrhea	☐ Hives or Rash	☐ Renal Dialysis	☐ Ulcers
				☐ Venereal Disease
				☐ Yellow Jaundice

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes, please explain: _____

COMMENTS

_____

_____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____