Swan Dentistry

Welcome to the office of J.D. "Pete" Swan, D.D.S.
(405) 720-2828

PATIENT INFORMATION

Name_____Prefers to be called "_____"
First **Middle** **Last**

Social Security #:_____ DOB:_____ Gender: Male / Female

Address_____City_____State_____Zip_____

Home #:_____Work #:_____ Cell #:_____

E-Mail Address:_____

Please circle one of the following: Single Married Divorced Partnered Widowed

Patient employer _____ Occupation _____

Employer Address _____ City _____State_____

Spouse Name _____Employer _____Work # _____

*Person to contact in case of emergency*_____*Phone:*_____

How did you hear about our office? _____

RESPONSIBLE PARTY **(Legal guardian if patient under the age of 18)**

Name of Person Responsible for this Account_____

Relationship to Patient_____ Telephone # _____

Address _____ City_____ State_____ Zip_____

DENTAL INSURANCE INFORMAION **(Please advise our office if you have secondary dental insurance)**

Policyholder _____DOB_____ Relationship to patient _____ Group _____

Name of Employer_____ Work Phone _____ SSN or ID _____

Insurance Carrier_____ Address:_____Phone:_____

Please be prepared to provide a copy of your <u>insurance card</u> and <u>photo ID</u> at check in

PATIENT'S MEDICAL AND DENTAL HISTORY

Former Dentist_____ **Date of last cleaning and xrays**_____

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

Please circle any of the following conditions that apply to you:

Bad breath	Grinding or clenching teeth	Sensitivity to heat or cold	Fluoridated water
Bleeding gums	Loose teeth or broken fillings	Sensitivity to sweets	Fluoride supplements
Clicking/popping jaw/pain	Periodontal treatment in past	Sensitivity when biting	Scaling/ Deep Cleaning
Food collection between teeth	Anxious about dental treatment	Sores or growths inside mouth	Dental Implants

Reason for today's visit _____

If you could change anything about your smile, what would you change?_____

Physician Name & Number:_____Pharmacy:_____

Please list recent surgeries or hospitalizations_____

Current medication list:_____

Allergies: Penicillin Latex Aspirin Codeine Other_____

Excessive bleeding with procedures? No Yes Do you use tobacco products? No Yes (how often _____)

****For Women Only: Are you pregnant? Yes No Possibly Nursing? Yes No Oral contraceptives? Yes No*

Please circle any of the following that may apply to you:

AIDS/HIV positive	Drug addiction/ treatment	Kidney Disease/ Dialysis
Alcohol Abuse	Eating Disorder	Lupus/ Autoimmune disease
Anemia	Emphysema	Liver Disease
Arthritis/Rheumatism	Epilepsy	Medication for ADD/ADHD
Artificial Heart Valves	Fainting/Dizzy Spells	Pain Management Program (Currently)
Angina Pectoris/Chest Pain	Family History Cardiovascular Disease	Radiation Treatment
Artificial Joints/Hip/Knee	Glaucoma	Recreational Drug Use
Back Problems	Heart Murmur	Scarlet Fever
Bleeding Abnormalities	Heart Surgery_____	Shortness of Breath
Blood Disease	Heart Pacemaker_____	Sleep Apnea
C- PAP use/ intolerance	Heart Valve Prolapse	Stroke
Cancer/ Tumors_____	Heart Failure	Swelling of Feet/Ankles
Chemotherapy	Heart Disease/Attack_____	Thyroid Disease
Circulatory Problems	Heart Bi-Pass/Stent _____	Tuberculosis
Congenital Heart Problems	Hay Fever/Allergies/Hives	Ulcer
Cortisone Treatment	Hemophilia	**OTHER:**_____
Current Psychiatric Care	Hepatitis/Type _____Year_____	_____
Diabetes	Herpes/Cold sore/ Fever Blisters	_____
Diet Medication/Fen-Phen use	High Blood Pressure	

******Certification and Assignment of Dental Benefits******

To the best of my knowledge, I certify that the previous information is complete and correct. I hereby authorize Dr. Swan to perform any and all forms of treatment, medication, and therapy that may be indicated in connection with the dental care of the patient above and further authorize and consent that the doctor chooses and employs such assistance as he deems fit. I also understand that previous to treatment, full explanation of the procedure(s) involved will be given by the doctor and/or team. I assign all dental insurance benefits directly to Dr. Swan and I understand that I am financially responsible for all charges incurred on the date of service, whether or not paid or covered by insurance. If the balance is more than 30 days past due, I understand that my account may be subject to interest.

I agree to pay for all services by a major credit card, cash, Lending Club or CareCredit at the time services are rendered.

Name **Signature** **Date**