533 St. Matthews Road ❖ info@swanseadentalcare.com ❖ 803.568.2077

PATIENT INFORMATION

			M F	S M D W	
Last Name	First	Middle	Sex	Marital Status	BIRTHDAY?

What is your PREFERRED NAME? Email Social Security Number

MAILING Address

Name of Employer Occupation Driver's License Number

WORK Address – Street/City/State/Zip

CELL Phone Number HOME Phone Number WORK Phone Number

How did you hear about Swansea Dental Care?

☐ Outdoor sign on road ☐ Dental Insurance ☐ Google search ☐ Family/friend: ______________________________________

☐ GPS Newspaper ☐ Facebook ☐ Mailer ☐ LMC-Swansea ☐ Other: ____

What is your **preferred** method of being contacted regarding **appointment reminders** at our office?

☐ Phone call ☐ Text ☐ Email

❖❖❖

YEAR of your last dental checkup: ____________________

What is your PRIMARY CONCERN that you would like to address **FIRST**? _____________________________

____

Rate your DENTAL ANXIETY/FEAR from **1-10** (1 = love being in the chair, 10 = knock me out for the exam)

1 2 3 4 5 6 7 8 9 10

Has anything ever happened in previous dental experiences that gave you reason to NOT return? Yes ☐ No ☐

If YES, tell us more: ____

SWANSEA DENTAL CARE

533 St. Matthews Road ❖ info@swanseadentalcare.com ❖ 803.568.2077

MEDICAL HISTORY

General health: Excellent ☐ Good ☐ Fair ☐ Poor ☐
Are you currently under the care of a physician? Yes ☐ No ☐ Date of last physical_____
Name of physician_____City_____
Do you smoke or use tobacco products? Yes ☐ No ☐ If yes, how much? _____

WOMEN:
Are you pregnant or think you may be? Yes ☐ No ☐ If yes, expected delivery date _____
Are you nursing? Yes ☐ No ☐
Are you taking birth control pills? Yes ☐ No ☐

Do you take any daily blood thinners (e.g. aspirin, Plavix, Coumadin)? Yes ☐ No ☐ If yes, please list below.
Do you take anything for the treatment or prevention of osteoporosis (e.g. Fosamax)? Yes ☐ No ☐ If yes, please list below.
Please list any medications you are taking now:

1)_____taken for_____ 4)_____taken for_____
2)_____taken for_____ 5)_____taken for_____
3)_____taken for_____ 6)_____taken for_____

Have you ever had (check those that apply):

AIDS or HIV.....	Yes ☐ No ☐	Heart valve surgery.....	Yes ☐ No ☐
Anemia…….....	Yes ☐ No ☐	Hepatitis/Liver disease.....	Yes ☐ No ☐
Arthritis ……..	Yes ☐ No ☐	High blood pressure……	Yes ☐ No ☐
Asthma or Hay fever……...	Yes ☐ No ☐	Joint replacement……	Yes ☐ No ☐
Back problems……....	Yes ☐ No ☐	Kidney disease……...	Yes ☐ No ☐
Blood transfusion…….	Yes ☐ No ☐	Lung disease (e.g. COPD, emphysema)….	Yes ☐ No ☐
Cancer/Chemotherapy…….	Yes ☐ No ☐	Lymph node enlargement/swollen gland…	Yes ☐ No ☐
Congenital heart disease.....	Yes ☐ No ☐	Mental health care……..	Yes ☐ No ☐
Cold sores or Fever blisters…….	Yes ☐ No ☐	Prolonged bleeding…….	Yes ☐ No ☐
Diabetes……	Yes ☐ No ☐	Radiation therapy…….....	Yes ☐ No ☐
Drug abuse……	Yes ☐ No ☐	Rheumatic fever……..	Yes ☐ No ☐
Eating disorders……	Yes ☐ No ☐	Seasonal allergies……	Yes ☐ No ☐
Epilepsy or Seizures…….	Yes ☐ No ☐	Sexually transmitted disease……...	Yes ☐ No ☐
Excessive urination and/or thirst……..	Yes ☐ No ☐	Sinus trouble……	Yes ☐ No ☐
Fainting spells.....	Yes ☐ No ☐	Stroke……...	Yes ☐ No ☐
Glaucoma…….....	Yes ☐ No ☐	Thyroid problems…….....	Yes ☐ No ☐
Heart disease/CABG surgery……...	Yes ☐ No ☐	Ulcers……...	Yes ☐ No ☐

If you have entered "yes" please explain: _____

Are you allergic to or have you had reactions to:

Local anesthetics like Novocain……	Yes ☐ No ☐	Latex/Rubber……	Yes ☐ No ☐
Penicillin or other antibiotics……	Yes ☐ No ☐	Aspirin……..	Yes ☐ No ☐
Sulfa drugs……	Yes ☐ No ☐	Any metal (e.g. gold, nickel, etc.)……...	Yes ☐ No ☐
Barbiturates, sedatives, sleeping pills……...	Yes ☐ No ☐	Other (please list)_____	

Patient Name:_____ **Date:**_____

Signature:_____

SWANSEA DENTAL CARE

533 St. Matthews Road ❖ info@swanseadentalcare.com ❖ 803.568.2077

DENTAL HEALTH AND TREATMENT QUESTIONNAIRE

Which topic(s) below do you have questions about that you want more info from us?

☐ Whiten all front teeth showing	☐ Rebuild fractured/broken tooth	☐ Straighten teeth
☐ Replace missing tooth	☐ Reduce bleeding from gums	☐ Eliminate dark or stained fillings
☐ Getting a denture/partial	☐ Remove any and all bad teeth	☐ NOTHING!

Please add anything you feel is important: _____

_____

1. Which of the following is the **ONE GREATEST** obstacle/objection you have to a dental office?
   a. No objections or obstacles- I come every six months and value my oral health
   b. Time- Not able to get off work, school schedule, or getting childcare, etc
   c. Have NOT had a sense of urgency- Nothing hurts so I don't come
   d. Budget- Know I need dental work done but need a way to make payments
   e. No trust- Felt I was told I needed treatment that I didn't need. I felt ripped off. I've had a Bad previous experience with dentist/staff.

2. Do you consider yourself a **PROACTIVE** person? Do you want to take care of a problem BEFORE it becomes worse?

   □ YES □ NO

3. Do you consider yourself more of a **REACTIVE** person? Would you rather wait until AFTER the problem starts to deal with it?

   □ YES □ NO

4. Do you clench or grind your teeth? □ YES □ NO

5. Have you ever had a sleep study? □ YES □ NO

6. Are you worried about losing teeth and having to wear a partial or denture? □ YES □ NO

7. When it comes to investing in your dental health, which ONE do you prefer?

   □ **Spread out payments** for 6-60 months with CareCredit
   □ **Getting a discount** for pre-paying in full
   □ Make **automatic payments** over a couple months

533 St. Matthews Road ❖ info@swanseadentalcare.com ❖ 803.568.2077

FINANCIAL POLICY, APPOINTMENT AGREEMENT AND HIPAA NOTIFICATION

- I have reviewed, understand, and agree to the FINANCIAL POLICY and APPOINTMENT AGREEMENT of Swansea Dental Care.
- I have been given and reviewed the CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION NOTICE OF PRIVACY PRACTICIES from Swansea Dental Care.

_____ _____

Signature of Patient or Personal Representative **Date**

_____

Print Name of Patient or Personal Representative

If you wish to transfer your dental records and x-rays from another dental office to Swansea Dental Care, please check below

☐ YES! I need the form to transfer my dental records from another office to Swansea Dental Care.

If you wish for Swansea Dental Care to release your protected health information (chart history, appointment times, and financial account info) to family members/caregivers, please check below

☐ YES! I need the form to authorize Swansea Dental Care to share my dental records with family or caregiver.

*Can Swansea Dental Care take your picture after a great appointment to share on our **Facebook** page?*

☐ Yes! I'd be happy to share my picture and name on Facebook like a lot of other people ☺

☐ No Way