



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?

\_\_\_\_\_ Social Security Number  
What is your PREFERRED NAME? Email

MAILING Address \_\_\_\_\_

\_\_\_\_\_ Driver's License Number  
Name of Employer Occupation

WORK Address – Street/City/State/Zip \_\_\_\_\_

\_\_\_\_\_ WORK Phone Number  
CELL Phone Number HOME Phone Number

**How did you hear about Swansea Dental Care?**

- Outdoor sign on road  Dental Insurance  Google search  Family/friend: \_\_\_\_\_
- Billboard  Facebook  Previous patient (Dr. Workman)  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: \_\_\_\_\_



### MEDICAL HISTORY

Health problems that you may have, or medications that you may be taking, could have an important interrelationship with the dentistry that you will be receiving. Thank you for answering the following questions.

General health:    Excellent     Good     Fair     Poor

Are you currently under the care of a physician?    Yes     No     Date of last physical \_\_\_\_\_

Name of physician \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

Do you smoke or use tobacco products?    Yes     No     If yes, how much? \_\_\_\_\_

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

If you have entered "yes" please explain: \_\_\_\_\_

**Are you allergic to or have you had reactions to:**

Local anesthetics like Novocain.....	Yes <input type="checkbox"/> No <input type="checkbox"/>	Latex/Rubber.....	Yes <input type="checkbox"/> No <input type="checkbox"/>
Penicillin or other antibiotics.....	Yes <input type="checkbox"/> No <input type="checkbox"/>	Aspirin.....	Yes <input type="checkbox"/> No <input type="checkbox"/>
Sulfa drugs.....	Yes <input type="checkbox"/> No <input type="checkbox"/>	Any metal (e.g. gold, nickel, etc.).....	Yes <input type="checkbox"/> No <input type="checkbox"/>
Barbiturates, sedatives, sleeping pills.....	Yes <input type="checkbox"/> No <input type="checkbox"/>	Other (please list) _____	

**Patient Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Signature:** \_\_\_\_\_



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**DENTAL HEALTH AND TREATMENT QUESTOINNAIRE**

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

- |                                                         |                                                         |                                                             |
|---------------------------------------------------------|---------------------------------------------------------|-------------------------------------------------------------|
| <input type="checkbox"/> Whiten all front teeth showing | <input type="checkbox"/> Rebuild fractured/broken teeth | <input type="checkbox"/> Straighten teeth                   |
| <input type="checkbox"/> Replace missing tooth          | <input type="checkbox"/> Reduce bleeding from gums      | <input type="checkbox"/> Eliminate dark or stained fillings |
| <input type="checkbox"/> Getting a denture/partial      | <input type="checkbox"/> Remove any and all bad teeth   | <input type="checkbox"/> NOTHING!                           |

Which dental treatment(s) below have you had previously? CHECK ANY AND ALL THAT APPLY

- |                                           |                                         |                                                               |
|-------------------------------------------|-----------------------------------------|---------------------------------------------------------------|
| <input type="checkbox"/> "Deep Cleanings" | <input type="checkbox"/> Fillings       | <input type="checkbox"/> Extractions (including wisdom teeth) |
| <input type="checkbox"/> Braces           | <input type="checkbox"/> Crowns/Bridge  | <input type="checkbox"/> Denture/Partial                      |
| <input type="checkbox"/> Root Canals      | <input type="checkbox"/> Dental Implant | <input type="checkbox"/> Root Canals                          |

Please add anything you feel is important: \_\_\_\_\_

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 don't have money to address the issues
- E. No trust- I 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.



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### **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 PRACTICES from Swansea Dental Care.
- Treatment will NOT be completed until **ALL** payment is received. I also acknowledge that any insurance benefits may help to pay towards costs, but payment is due at time of service. Otherwise, my account will be sent to a collections agency which will negatively impact my credit history.

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**Signature of Patient or Personal Representative**

**Date**

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**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 indicate 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 indicate 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 your Facebook like a lot of other people

No, thanks