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

PATIENT INFORMATION

Last Name	First	Middle	Sex (M F)	Marital Status (S M D W)	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: ____________________

☐ Billboard ☐ 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: ____________________

SWANSEA DENTAL CARE

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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 ☐ 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:_____

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DENTAL HEALTH AND TREATMENT QUESTOINNAIRE

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

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

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

☐ "Deep Cleanings"
☐ Braces
☐ Root Canals
☐ Fillings
☐ Crowns/Bridge
☐ Dental Implant
☐ Extractions (including wisdom teeth)
☐ Denture/Partial
☐ 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 PRACTICIES 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.

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 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