Swartz Family Dentistry
Larkin P. Swartz, DDS, LLC

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Dear Valued Patient,

Welcome to the dental practice of Dr. Larkin Swartz, and thank you for allowing us to care for your family's dental needs. We pride ourselves on providing the highest quality dental treatment tailored to suit you, in a warm and caring atmosphere. We are committed to earning your trust and confidence as partners in your health and well-being.

Our Mission: We have a patient centered approach. This means we promise to listen to your needs and schedule the time you deserve to address those needs. We also promise to deliver our highly skilled care in an affordable manner.

At your first Visit: The first time you visit our office, we want to learn your values and needs. This means our first appointment will include a thorough medical and dental history, comprehensive oral evaluation, x-rays as needed, and a personal consultation with Dr. Swartz. We reserve a full hour of our schedule for this consult. This is the time to discuss the types of dental therapy we may recommend and prioritize treatment. This first visit is also an opportunity to meet with our financial coordinator to discuss any financial arrangements or dental insurance benefit estimates.

Future Appointments: We understand that everyone's time is valuable. To accommodate our patients, Dr. Swartz offers late appointments on Monday (noon-7pm) and early appointments Tuesday-Thursday (7am-4pm). Dr. Swartz also keeps an on-call line that makes him accessible to you 24hrs per day for emergencies.

Appointment Commitment Policy: We reserve your appointment time especially for you! This means that at the time an appointment is made, we consider it confirmed. As a courtesy to you, we often reach out to remind you of a scheduled visit by text or email. Should something prevent you from keeping this time commitment we request that you notify us no later than 48 hours prior to your visit. If you fail to keep your time commitments with us more than twice in any 12-month period we will be happy to forward your dental records to another provider, as we will no longer be able to properly treat you in our office.

Dental Insurance: Sometimes a dental insurance plan will have limits to coverage, dictated by your employer or individual plan. While Dr. Swartz works closely with many dental insurances, he may make recommendations for your health that are not covered under your plan. We strive to provide you with accurate estimates of benefit coverage, but ultimately the fees for your services are your responsibility. As a courtesy to you, we file claims automatically to your primary insurance. We are also willing to help you to fill out claims for reimbursement from any secondary insurance.

Account Balances: Our financial coordinator strives to maintain an up to date and accurate statement for your account. Payment is due at the time we provide services, and we take most forms of payment including cash, check, credit card, PayPal, and financing options through "Care Credit." We may occasionally mail you a statement as a reminder of any delinquent balances. If you allow a delinquent balance to go unpaid for more than 90 days, your balance will be turned over to PDQ Collections Inc and a report will be sent to Experian. This will result in your dismissal from our practice.

Once again thank you for allowing us to serve your dental needs! If you have any questions or would like to learn more about our practice, please give us a call at **706-234-3996.** We look forward to providing you with the best quality care possible!

Dr. Larkin Swartz & Staff

_____
Patient Name (please print)

_____ _____
Patient/Guardian Signature Date

Address_____

_____

City_____ State/Zip_____

Home Phone_____

Work Phone_____

Cell Phone_____

Genetic Sex: ○ Male ○ Female

Marital Status:_____

Birthdate_____ Age_____

Social Security #_____

Driver's License #_____

Email_____

All information provided above will be used in the creation and maintenance of your accurate dental chart. No information will be disclosed to any third party without your express written consent. For more information regarding the use of your protected health information in healthcare covered entities, please visit: https://www.hhs.gov/sites/default/files/ocr/privacy/hipaa/understanding/coveredentities/sharingfortpo.pdf

Time 2:18 PM | Dr. Larkin Swartz | Date 3/25/2017

Eaglesoft Medical History

Patient Name: | Birth Date: | Date Created:

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

Are you under a physician's care now?	○ Yes ○ No	If yes
Have you ever been hospitalized or had a major operation?	○ Yes ○ No	If yes
Have you ever had a serious head or neck injury?	○ Yes ○ No	If yes
Are you taking any medications, pills, or drugs?	○ Yes ○ No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	○ Yes ○ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	○ Yes ○ No	If yes
Are you on a special diet?	○ Yes ○ No	
Do you use tobacco?	○ Yes ○ No	

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

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

Do you use controlled substances?	○ Yes ○ No	If yes
Other?	☐	If yes

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

AIDS/HIV Positive ○ Yes ○ No	Cortisone Medicine ○ Yes ○ No	Hemophilia ○ Yes ○ No	Radiation Treatments ○ Yes ○ No
Alzheimer's Disease ○ Yes ○ No	Diabetes ○ Yes ○ No	Hepatitis A ○ Yes ○ No	Recent Weight Loss ○ Yes ○ No
Anaphylaxis ○ Yes ○ No	Drug Addiction ○ Yes ○ No	Hepatitis B or C ○ Yes ○ No	Renal Dialysis ○ Yes ○ No
Anemia ○ Yes ○ No	Easily Winded ○ Yes ○ No	Herpes ○ Yes ○ No	Rheumatic Fever ○ Yes ○ No
Angina ○ Yes ○ No	Emphysema ○ Yes ○ No	High Blood Pressure ○ Yes ○ No	Rheumatism ○ Yes ○ No
Arthritis/Gout ○ Yes ○ No	Epilepsy or Seizures ○ Yes ○ No	High Cholesterol ○ Yes ○ No	Scarlet Fever ○ Yes ○ No
Artificial Heart Valve ○ Yes ○ No	Excessive Bleeding ○ Yes ○ No	Hives or Rash ○ Yes ○ No	Shingles ○ Yes ○ No
Artificial Joint ○ Yes ○ No	Excessive Thirst ○ Yes ○ No	Hypoglycemia ○ Yes ○ No	Sickle Cell Disease ○ Yes ○ No
Asthma ○ Yes ○ No	Fainting Spells/Dizziness ○ Yes ○ No	Irregular Heartbeat ○ Yes ○ No	Sinus Trouble ○ Yes ○ No
Blood Disease ○ Yes ○ No	Frequent Cough ○ Yes ○ No	Kidney Problems ○ Yes ○ No	Spina Bifida ○ Yes ○ No
Blood Transfusion ○ Yes ○ No	Frequent Diarrhea ○ Yes ○ No	Leukemia ○ Yes ○ No	Stomach/Intestinal Disease ○ Yes ○ No
Breathing Problems ○ Yes ○ No	Frequent Headaches ○ Yes ○ No	Liver Disease ○ Yes ○ No	Stroke ○ Yes ○ No
Bruise Easily ○ Yes ○ No	Genital Herpes ○ Yes ○ No	Low Blood Pressure ○ Yes ○ No	Swelling of Limbs ○ Yes ○ No
Cancer ○ Yes ○ No	Glaucoma ○ Yes ○ No	Lung Disease ○ Yes ○ No	Thyroid Disease ○ Yes ○ No
Chemotherapy ○ Yes ○ No	Hay Fever ○ Yes ○ No	Mitral Valve Prolapse ○ Yes ○ No	Tonsillitis ○ Yes ○ No
Chest Pains ○ Yes ○ No	Heart Attack/Failure ○ Yes ○ No	Osteoporosis ○ Yes ○ No	Tuberculosis ○ Yes ○ No
Cold Sores/Fever Blisters ○ Yes ○ No	Heart Murmur ○ Yes ○ No	Pain in Jaw Joints ○ Yes ○ No	Tumors or Growths ○ Yes ○ No
Congenital Heart Disorder ○ Yes ○ No	Heart Pacemaker ○ Yes ○ No	Parathyroid Disease ○ Yes ○ No	Ulcers ○ Yes ○ No
Convulsions ○ Yes ○ No	Heart Trouble/Disease ○ Yes ○ No	Psychiatric Care ○ Yes ○ No	Venereal Disease ○ Yes ○ No
Yellow Jaundice ○ Yes ○ No			

Have you ever had any serious illness not listed	○ Yes ○ No	If yes

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:

X Date:_____