



Welcome!

Rebecca Swertloff DDS, Inc.

Family Dentistry

Thank you for selecting our dental healthcare team!

We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us – we will be happy to help.

Date: _____

Patient Information (CONFIDENTIAL)

Patient's SS#: _____

Patient's Sex: F M

First: _____ M.I.: _____ Last: _____ Birthdate: ____ / ____ / ____

Home Phone: (____) _____

Address: _____ City: _____ State: _____ Zip: _____

Email: _____ Mobile Phone: (____) _____

Do you prefer to receive calls at your: Home Work Mobile Email Work Phone: (____) _____

Check Appropriate Box: Minor Single Married Divorced Widowed Separated

If a Student, Name of School/College: _____ City: _____ State: _____ Zip: _____

Spouse or Parent/Guardian's Name: _____ Employer: _____ Work Phone: (____) _____

Whom may we thank for referring you? _____ How did you hear about us? _____

Person to contact in case of emergency: _____ Phone: (____) _____

Responsible Party

Name of Person Responsible for this Account: _____

Relationship to Patient: _____

Address: _____ City: _____ State: _____ Zip: _____

Email: _____ Home Phone: (____) _____

Driver's License #: _____ Birthdate: ____ / ____ / ____ Mobile Phone: (____) _____

Employer: _____ Work Phone: (____) _____ SS#: _____

Is this person currently a patient in our office: Yes No

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full is required at each appointment.

Cash Personal Check Credit Card: VISA Mastercard I wish to discuss the office's payment policy

Insurance Information

Name of Insured: _____ Relationship to Patient: _____

Birthdate: ____ / ____ / ____ SS#: _____ Date Employed: _____

Name of Employer: _____ Union or Local#: _____ Work Phone: _____

Address of Employer: _____ City: _____ State: _____ Zip: _____

Insurance Company: _____ Group #: _____ Policy ID#: _____

Insurance Co. Address: _____ City: _____ State: _____ Zip: _____

How much is your deductible? _____ How much have you used? _____ Max. annual benefit: _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? Yes No

IF YES, COMPLETE THE FOLLOWING:

Name of Insured: _____ Relationship to Patient: _____

Birthdate: ____ / ____ / ____ SS#: _____ Date Employed: _____

Name of Employer: _____ Union or Local#: _____ Work Phone: _____

Address of Employer: _____ City: _____ State: _____ Zip: _____

Insurance Company: _____ Group #: _____ Policy ID#: _____

Insurance Co. Address: _____ City: _____ State: _____ Zip: _____

How much is your deductible? _____ How much have you used? _____ Max. annual benefit: _____

Patient Medical History

Physician: _____

Office Phone: () _____

Date of Last Exam: / /

	Yes	No		Yes	No
Are you under medical treatment now?.....	<input type="checkbox"/>	<input type="checkbox"/>	Are you wearing contact lenses?.....	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?.....	<input type="checkbox"/>	<input type="checkbox"/>	<i>Are you allergic to or have you any reactions to the following?</i>		
If yes, please explain: _____			Local Anesthetics (e.g. Novocain).....	<input type="checkbox"/>	<input type="checkbox"/>
Are you taking any medication(s) including non-prescription medicine?.....	<input type="checkbox"/>	<input type="checkbox"/>	Penicillin or any other Antibiotics.....	<input type="checkbox"/>	<input type="checkbox"/>
If yes, what medications?: _____			Sulfa Drugs.....	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever taken Fen-Phen/Redux?.....	<input type="checkbox"/>	<input type="checkbox"/>	Barbiturates.....	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing bisphosphonates?.....	<input type="checkbox"/>	<input type="checkbox"/>	Sedatives.....	<input type="checkbox"/>	<input type="checkbox"/>
Have you taken Viagra, Revati, Cialis or Levitra in the last 24 hours?.....	<input type="checkbox"/>	<input type="checkbox"/>	Iodine.....	<input type="checkbox"/>	<input type="checkbox"/>
Do you use tobacco?.....	<input type="checkbox"/>	<input type="checkbox"/>	Aspirin.....	<input type="checkbox"/>	<input type="checkbox"/>
Do you use controlled substances?.....	<input type="checkbox"/>	<input type="checkbox"/>	Any Metals (e.g. nickel, mercury, etc.).....	<input type="checkbox"/>	<input type="checkbox"/>
Do you have or have you had any of the following?			Latex Rubber.....	<input type="checkbox"/>	<input type="checkbox"/>
			Other _____		
			<i>Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?</i>		
				<input type="checkbox"/>	<input type="checkbox"/>
			<i>Women Only:</i>		
			a) Are you pregnant or thinking you may be pregnant?.....	<input type="checkbox"/>	<input type="checkbox"/>
			b) Are you nursing?.....	<input type="checkbox"/>	<input type="checkbox"/>
			c) Are you taking oral contraceptives?.....	<input type="checkbox"/>	<input type="checkbox"/>

	Yes	No		Yes	No		Yes	No
High Blood Pressure.....	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease.....	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pains.....	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack.....	<input type="checkbox"/>	<input type="checkbox"/>	Cardiac Pacemaker.....	<input type="checkbox"/>	<input type="checkbox"/>	Easily Winded.....	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever.....	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur.....	<input type="checkbox"/>	<input type="checkbox"/>	Stroke.....	<input type="checkbox"/>	<input type="checkbox"/>
Swollen Ankles.....	<input type="checkbox"/>	<input type="checkbox"/>	Angina.....	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever / Allergies.....	<input type="checkbox"/>	<input type="checkbox"/>
Fainting / Seizures.....	<input type="checkbox"/>	<input type="checkbox"/>	Frequently Tired.....	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis.....	<input type="checkbox"/>	<input type="checkbox"/>
Asthma.....	<input type="checkbox"/>	<input type="checkbox"/>	Anemia.....	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Therapy.....	<input type="checkbox"/>	<input type="checkbox"/>
Low Blood Pressure.....	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema.....	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma.....	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy / Convulsions.....	<input type="checkbox"/>	<input type="checkbox"/>	Cancer.....	<input type="checkbox"/>	<input type="checkbox"/>	Recent Weight Loss.....	<input type="checkbox"/>	<input type="checkbox"/>
Leukemia.....	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis.....	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease.....	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes.....	<input type="checkbox"/>	<input type="checkbox"/>	Joint Replacement or Implant.....	<input type="checkbox"/>	<input type="checkbox"/>	Heart Trouble.....	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Diseases.....	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis / Jaundice.....	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory Problems.....	<input type="checkbox"/>	<input type="checkbox"/>
AIDS or HIV Infection.....	<input type="checkbox"/>	<input type="checkbox"/>	Sexually Transmitted Disease.....	<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse.....	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Problem.....	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Troubles / Ulcers.....	<input type="checkbox"/>	<input type="checkbox"/>	Other _____	<input type="checkbox"/>	<input type="checkbox"/>

Patient Dental History

Name of Previous Dentist and Location: _____

Date of Last Exam: / /

	Yes	No		Yes	No
Do your gums bleed while brushing or flossing?.....	<input type="checkbox"/>	<input type="checkbox"/>	Do you have frequent headaches?.....	<input type="checkbox"/>	<input type="checkbox"/>
Are your teeth sensitive to hot or cold liquids/fluids?.....	<input type="checkbox"/>	<input type="checkbox"/>	Do you clench or grind your teeth?.....	<input type="checkbox"/>	<input type="checkbox"/>
Are your teeth sensitive to sweet or sour liquids/fluids?.....	<input type="checkbox"/>	<input type="checkbox"/>	Do you bite your lips or cheeks frequently?.....	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel pain to any of your teeth?.....	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had any difficult extractions in the past?.....	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any sores or lumps in or near your mouth?.....	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had any prolonged bleeding following extractions?.....	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any head, neck or jaw injuries?.....	<input type="checkbox"/>	<input type="checkbox"/>	Have you had any orthodontic treatment?.....	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever experienced any of the following problems in your jaw?			Do you wear dentures or partials?.....	<input type="checkbox"/>	<input type="checkbox"/>
Clicking.....	<input type="checkbox"/>	<input type="checkbox"/>	If yes, date of placement _____		
Pain (joint, ear, side of face).....	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever received oral hygiene instructions regarding the care of your teeth and gums?.....	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty in opening or closing.....	<input type="checkbox"/>	<input type="checkbox"/>	Do you like your smile?.....	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty in chewing.....	<input type="checkbox"/>	<input type="checkbox"/>			

Authorization and Release

Payment is due in full at the time of treatment unless prior arrangements have been approved. This office accepts insurances. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment of examination rendered to my insurance company. I understand the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment, with my informed consent.