Swearingen DENTAL
Dedicated to excellence. Dedicated to YOU!

48959 Calcutta Smith Ferry Road, East Liverpool, OH 43920
330.385.4126

PATIENT INFORMATION

First Name:	Middle Name:	Last Name:	Nickname:
Date of Birth:	Age:	Gender:	SSN:	Marital Status:
Mailing Address:	City:	State:	Zip:
Email Address:	Occupation:		
Employer:	Cell Phone:	Home Phone:	Work Phone:
Employer Address:	Employer City:	State:	Zip:

PREFERRED METHOD OF COMMUNICATION

What is the best way to contact you?

Home Phone [ ] Cell Phone [ ] Text [ ]
Work Phone [ ] Email [ ] Other [ ]
Facebook [ ]

INSURANCE POLICY HOLDER IF OTHER THAN PATIENT

First Name:	Middle Initial:	Last Name:	SSN:
Address:	City:	State:	Zip:
Date of Birth:	Home Phone:	Cell Phone:	
Employer:			
Employer Address:	Employer City:	State:	Zip:

PERSON TO CONTACT IN CASE OF EMERGENCY

Contact Relationship:	First Name:	Last Name:
Home Phone:	Cell Phone:	Employer Phone:

Do you authorize this office to discuss your care or treatment with any party besides yourself: [ ] yes [ ] no

Other Authorized Person(s) (if any):

DENTAL INSURANCE INFORMATION

Primary Insurance:	Employer:		
Policy Holder Name:	Date of Birth:	Policy Holder SSN:	
Insurance Address:	City:	State:	Zip:
Phone Number:	Group Number:	Member ID:	
Secondary Insurance:	Employer:		
Policy Holder Name:	Date of Birth:	Policy Holder SSN:	
Secondary Ins Address:	City:	State:	Zip:
Secondary Ins Phone Number:	Group Number:	Member ID:	

HOW DID YOU HEAR ABOUT OUR OFFICE? IS THERE SOMEONE WE CAN THANK FOR REFERRING YOU?

Billboard [ ]	Friend [ ] Name of referring friend:		
Doctor [ ]	Internet Search [ ]	Our Website [ ]	TV Commercial [ ]
Facebook [ ]	Mobile App [ ]	Other Social Media [ ]	Yellow Pages [ ]

IS THERE A FAMILY MEMBER FOR WHOM YOU WOULD LIKE TO SCHEDULE AN APPOINTMENT?

Name:

MEDICAL HEALTH HISTORY

Although dental professionals primarily treat the area in and around the mouth, your mouth is a part of your entire body. Health problems you may have or medications you may be taking could impact your oral health and may have an important relationship with your dental care.

Thank you for answering the following questions:

Do you have or have you had an of the following? **Please circle all that apply.** If necessary, use the back of the form to explain.

Acid Reflux/GERD
AIDS/HIV Positive
Alzheimer's Disease
Anaphylaxis
Anemia
Angina
Arthritis/Gout
Artificial Heart Valve
Artificial Joint
Asthma
Blood Disease
Blood Transfusion
Breathing Problems
Bruise Easily
Cancer
Chemotherapy
Chest Pains
Cold Sores/Fever Blisters
Congenital Heart Disorder
Convulsions
Yellow Jaundice

Cortisone Medication
Diabetes
Drug Addiction
Easily Winded
Emphysema
Epilepsy or Seizures
Excessive Bleeding
Excessive Thirst
Fainting Spells/Dizziness
Frequent Cough
Frequent Diarrhea
Frequent Headaches
Genital Herpes
Glaucoma
Hay Fever
Heart Attack/Failure
Heart Murmur
Heart Pacemaker
Heart Trouble/Disease
Hemophilia
Hepatitis A

Hepatitis B or C
Herpes
High Blood Pressure
High Cholesterol
Hives or Rash
Hypoglycemia
Irregular Heartbeat
Kidney Problems
Leukemia
Liver Disease
Low Blood Pressure
Lung Disease
Mitral Valve Prolapse
Osteoporosis
Pain in Jaw Joints
Parathyroid Disease
Psychiatric Care
Radiation Treatments
Recent Weight Loss
Renal Dialysis
Rheumatic Fever

Rheumatism
Scarlet Fever
Shingles
Sickle Cell Disease
Sinus Trouble
Sleep Apnea
Spina Bifida
Stomach/Intestinal Disease
Stroke
Swelling of Limbs
Thyroid Disease
(Hypothyroid/Hyperthyroid)
Tonsillitis
Tuberculosis
Tumors or Growths
Ulcers
Venereal Disease
Lyme Disease

Any medical conditions not listed above:_____

PHARMACY INFORMATION

Pharmacy name:	Address:	Phone:

Are you under a physician's care?	Yes	No	If yes, please explain:
Who is your primary care physician?	Name:		Phone#:
Do you have a cardiologist?	Name:		Phone#:
Have you had a joint replacement?	Date of surgery:		
Orthopedic Surgeon	Name:		Phone#:
Have you had an organ transplant?	Date of surgery:		
Surgeon	Name:		Phone#:
Have you ever been hospitalized or had a major operation?	Yes	No	Please list all surgeries and dates:
Have you ever had any serious head or neck injuries?	Yes	No	If yes, please explain:
Are you taking any medications, vitamins, or supplements?	Yes	No	Please list all medications and supplements:
Are you currently taking, or have you ever taken a medication for osteoporosis (Fosamax, Boniva, Actonel) or any other medications containing bisphosphonates?	Yes	No	
Are you taking any blood thinning medications such as Coumadin or Plavix?	Yes	No	
Are you on a special diet?	Yes	No	If yes, please explain:
Do you use controlled substances?	Yes	No	If yes, please explain:
Do you use tobacco?	Yes	No	

Are you allergic to any of the following?

[ ] Aspirin [ ] Penicillin [ ] Codeine [ ] Acrylic

[ ] Metal [ ] Latex [ ] Sulfa Drugs [ ] Local Anesthetics

[ ] Other Please List: _____

WOMEN	
Are you:	
[ ] Pregnant/Trying to get pregnant	[ ] Nursing
[ ] Experiencing a late menstrual cycle	[ ] Taking oral contraceptives

DENTAL HEALTH HISTORY

Date of last dental visit:	What was done at that visit?
Date of last hygiene visit?	Date of last complete xrays?
What is the most important thing to you about your future smile and dental health?	
What is your biggest concern related to your dental visit today?	
ON A SCALE OF 1 -10, WITH 10 BEING THE HIGHEST, PLEASE RATE THE FOLLOWING:	
How important is your dental health to you?	Where would you rate your current dental health?
Where do you want your dental health to be?	
IF I COULD CHANGE MY SMILE, I WOULD:	

Make it whiter [ ] yes [ ] no	Close spaces [ ] yes [ ] no	Make it straighter [ ] yes [ ] no
Replace black, metal fillings with tooth-colored restorations [ ] yes [ ] no		Repair chipped teeth [ ] yes [ ] no
Replace old crowns that don't match [ ] yes [ ] no		Have a smile makeover [ ] yes [ ] no
Replace missing teeth [ ] yes [ ] no		

Are you experiencing any dental problems now [ ] yes [ ] no	If yes, please describe:

GENERAL DENTAL HISTORY

1. Have you had:
   - Regular preventive dental care? [ ] Yes [ ] No
   - Gum treatment? [ ] Yes [ ] No
   - Oral surgery treatment? [ ] Yes [ ] No
   - Bite (occlusion) treatment? [ ] Yes [ ] No
   - Orthodontic care (braces)? [ ] Yes [ ] No
   - Root canal treatment? [ ] Yes [ ] No
   - Dentures or bridgework? [ ] Yes [ ] No
2. Do you now have:
   - A bite problem? [ ] Yes [ ] No
   - Bleeding gums? [ ] Yes [ ] No
   - Gum pain or swelling? [ ] Yes [ ] No
   - Food catching between teeth? [ ] Yes [ ] No
   - Any sensitive teeth? [ ] Yes [ ] No
   - Any toothaches? [ ] Yes [ ] No
   - Bad breath? [ ] Yes [ ] No
   - Loose or moving teeth? [ ] Yes [ ] No
   - Dry mouth problems? [ ] Yes [ ] No
   - White areas in mouth? [ ] Yes [ ] No
   - Frequent cold sores or mouth sores/ulcers? [ ] Yes [ ] No
3. Can you:
   - Chew your food effectively? [ ] Yes [ ] No
   - Talk and smile without worrying about your teeth? [ ] Yes [ ] No
   - Bite without pain? [ ] Yes [ ] No
4. Do you/your:
   - Brush your teeth daily? [ ] Yes [ ] No
   - Floss your teeth daily? [ ] Yes [ ] No
   - Clean your teeth in other ways? [ ] Yes [ ] No
   - Use your fluoride treatment? [ ] Yes [ ] No
   - Use mouthwash? [ ] Yes [ ] No
   - Form tarter quickly? [ ] Yes [ ] No
   - Use a water pick? [ ] Yes [ ] No
   - Grind or clench your teeth? [ ] Yes [ ] No
   - Have a concern over loosing teeth? [ ] Yes [ ] No
   - Chew mostly on one side? [ ] Yes [ ] No
   - Eat a lot of sweets/sugary food? [ ] Yes [ ] No
   - Teeth interfere with your speech? [ ] Yes [ ] No
   - Like the appearance of your smile? [ ] Yes [ ] No
   - Like the color of your teeth? [ ] Yes [ ] No
   - Teeth break or fracture easily? [ ] Yes [ ] No
   - Wear a retainer, mouth appliances, brux splint or mouth guard? [ ] Yes [ ] No
5. Do you or have you ever experienced:
   - Difficulty opening/closing jaw? [ ] Yes [ ] No
   - Difficulty chewing? [ ] Yes [ ] No
   - Pain in or discomfort in your jaw? [ ] Yes [ ] No
   - Clicking or popping of your jaw? [ ] Yes [ ] No
   - Pain in or around your ear or the side of your face? [ ] Yes [ ] No
   - Jaw muscle tiredness or soreness? [ ] Yes [ ] No

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

SIGNATURE_____**DATE**_____