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 ☐ Other: (please indicate):_____
☐ 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
Are you under medical treatment now?	☐	☐
Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?	☐	☐
If yes, please explain: _____		
Are you taking any medication(s) including non-prescription medicine?	☐	☐
If yes, what medications?: _____		
Have you ever taken Fen-Phen/Redux?	☐	☐
Have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing bisphosphonates?	☐	☐
Have you taken Viagra, Revati, Cialis or Levitra in the last 24 hours?	☐	☐
Do you use tobacco?	☐	☐
Do you use controlled substances?	☐	☐

	Yes	No
Are you wearing contact lenses?	☐	☐
Are you allergic to or have you any reactions to the following?		
Local Anesthetics (e.g. Novocain)	☐	☐
Penicillin or any other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Any Metals (e.g. nickel, mercury, etc.)	☐	☐
Latex Rubber	☐	☐
*Other*_____		
Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?	☐	☐
Women Only:		
a) Are you pregnant or thinking you may be pregnant?	☐	☐
b) Are you nursing?	☐	☐
c) Are you taking oral contraceptives?	☐	☐

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

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

Patient Dental History

Name of Previous Dentist and Location: _____ Date of Last Exam: __/__/__

	Yes	No
Do your gums bleed while brushing or flossing?	☐	☐
Are your teeth sensitive to hot or cold liquids/fluids?	☐	☐
Are your teeth sensitive to sweet or sour liquids/fluids?	☐	☐
Do you feel pain to any of your teeth?	☐	☐
Do you have any sores or lumps in or near your mouth?	☐	☐
Have you had any head, neck or jaw injuries?	☐	☐
Have you ever experienced any of the following problems in your jaw?		
Clicking	☐	☐
Pain (joint, ear, side of face)	☐	☐
Difficulty in opening or closing	☐	☐
Difficulty in chewing	☐	☐

	Yes	No
Do you have frequent headaches?	☐	☐
Do you clench or grind your teeth?	☐	☐
Do you bite your lips or cheeks frequently?	☐	☐
Have you ever had any difficult extractions in the past?	☐	☐
Have you ever had any prolonged bleeding following extractions?	☐	☐
Have you had any orthodontic treatment?	☐	☐
Do you wear dentures or partials?	☐	☐
*If yes, date of placement*_____		
Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	☐	☐
Do you like your smile?	☐	☐

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 Rebecca Swertloff DDS, Inc. 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.

Signature: _____ Date: __/__/__ Staff Initials: _____