# *Welcome to Swift Creek Dental Center*

Dr. Matthew R. Estes  Dr. Jeffrey J. Koelmel

Today's Date: ____ / ____ / _____

## Patient Information

Last Name:_____ Legal Name:_____ MI: ____ Nickname: _____

Social Security #: _____ Birth Date: ____ /____ /____ Age: _____ Sex: ❒ M ❒ F

❒ Married ❒ Single Full time student? ❒ Y ❒ N If so, where: _____

Street Address: _____ City, State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Best number to reach you during the day? ❒ Home ❒ Cell ❒ Work ❒ Other: _____

E-mail Address: _____

How would you prefer to receive confirmations? ❒ Phone, ❒ Text, ❒ E-mail

Who is responsible for this account? _____

Spouse's Last Name: _____ First: _____ MI: _____

Spouse Social Security #: _____ Birth Date: ____ /____ /_____

Other Family Members Seen Here: _____

How did you hear about our office? _____

## Primary Insurance Information

Primary Dental Insurance Carrier:_____

Insured's Name: _____ Group Number: _____

Primary Insured SSN (or ID#): _____ Employer: _____

Insurance Co. Address:_____

City, State: _____ Zip: _____ Ins. Co. Phone: _____

Patient's Relationship to the Insured: _____

## Secondary Insurance Information

Secondary Dental Insurance Carrier: _____

Insured's Name: _____ Group Number: _____

Secondary Insured SSN (or ID#): _____ Employer: _____

Insurance Co. Address: _____

City, State: _____ Zip: _____ Ins. Co. Phone: _____

Patient's Relationship to the Insured: _____

## Previous Dental Information

Previous Dentist: _____ Last Seen?: _____

Address: _____ Phone: _____

## In Case of Emergency

Name of Relative or Local Friend: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

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## Medical Information

Are you currently under a physicians care? ❒ Yes ❒ No  Surgery last 5 years? ❒ Yes ❒ No

If yes, Physician Name: _____ Phone: _____

Are you pregnant ? ❒ Yes ❒ No ❒ NA  If Yes, expected delivery date: _____

If yes, Physician Name: _____ Phone: _____

Are you currently taking any medications or herbal supplements? ❒ Yes ❒ No

If yes, please list on the next page.

Are there any special needs or disabilities that we should know about? ❒ Yes ❒ No

If yes, please describe: _____

Do you have any allergies or sensitive to any drugs or products such as: ❒ Penicillin, ❒ Aspirin,

❒ Codeine, ❒ Latex, ❒ Local Anesthetics, or ❒ Other (list) _____

If yes, type of reaction: _____

## Medical History

Have you ever had any of the following?:

| | Yes | No | | Yes | No | | Yes | No |
|---|---|---|---|---|---|---|---|---|
| Anemia | ❒ | ❒ | Sinus Problems | ❒ | ❒ | Chemotherapy/Cancer | ❒ | ❒ |
| AIDS/HIV | ❒ | ❒ | Osteoporsis | ❒ | ❒ | Mitral Vavle Prolapse | ❒ | ❒ |
| High Blood Pressure | ❒ | ❒ | Heart Murmur | ❒ | ❒ | Panic Disorder/Anxiety | ❒ | ❒ |
| Artificial Joints | ❒ | ❒ | Heart Problems | ❒ | ❒ | Rheumatic Fever | ❒ | ❒ |
| Asthma | ❒ | ❒ | Stroke | ❒ | ❒ | Other Blood Disorders | ❒ | ❒ |
| Arthritis | ❒ | ❒ | Sleep Apnea | ❒ | ❒ | Kidney Disease | ❒ | ❒ |
| Excessive Bleeding | ❒ | ❒ | Strong Gag Reflex | ❒ | ❒ | Epilepsy or Seizures | ❒ | ❒ |
| Coumadin | ❒ | ❒ | Fainting/Convulsions | ❒ | ❒ | Hepatitis | ❒ | ❒ |
| Diabetic | ❒ | ❒ | Tuberculosis | ❒ | ❒ | Venereal Disease | ❒ | ❒ |
| Emphysema | ❒ | ❒ | Thyroid Problems | ❒ | ❒ | Tobacco Prod./Smoke | ❒ | ❒ |

If you checked "yes" for any of the above, please explain: _____

_____

Do you require antibiotics for dental treatment? Yes ❒ No ❒

Please list any other health information you may feel may be important: _____

_____

All information provided is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the dental practice. I understand that I am financially responsible for any balance. I also authorize Swift Creek Dental or Insurance Company to release any information required to process my claims.

Patient/Guardian Signature: _____ Date: ____ /_____ /_____

## Office Use Only . . . Office Use Only . . . Office Use Only

I verbally reviewed the medical/dental information with this patient. Initials: _____ Date: _____

Doctor's Comments:_____

_____

Date: _____ Comments: _____ Initials: _____

Date: _____ Comments: _____ Initials: _____

Date: _____ Comments: _____ Initials: _____

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## Medical Supplement

If you are currently taking any medications or herbal supplements? Please complete the folllowing:

| Medication | Dosage | Reason |
|---|---|---|
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## Office/Patient Agreement

Deductibles and co-pays are requested and appreciated at the time services are rendered. Financial terms include cash, check, most major credit cards, care credit and approved payment plans. Dental insurance is accepted, however the patient is responsible for any balance not paid by the insurance company.

A 24-hour notification is required in the event an appointment must be cancelled. This allows the office to schedule other patients in that time slot. There will be a $50 charge for missed appointments without proper notification.

I understand I am responsible for any collection fees, court costs, attorney fees and cancellation fees that this account may incur.

Patient/Guardian Signature: _____ Date: ____ /_____ /_____