

Patient Registration

Glenn T. Swindle, Jr., D.D.S., P.C.
Brett Hester, D.M.D, P.C.

Date _____

Name (first, middle, last) _____ Preferred Name _____

Street Address _____ City _____ State _____ Zip _____

Home Phone (_____) _____ Work (_____) _____ Cell (_____) _____

Birthdate _____ Social Security Number _____ Gender: ___ Male ___ Female

Employer _____ Occupation _____ Address _____

___ Married ___ Divorced ___ Widowed ___ Single ___ Separated ___ Minor If student, name of school _____

Spouse's Name _____ Employer _____ Work Phone (_____) _____

Who should we contact in case of emergency? _____ Phone(_____) _____

Person responsible for this account _____ Relationship to patient _____

Whom may we thank for referring you? _____

DENTAL INSURANCE

Name of Insured _____ Relationship to Patient _____ Birthdate _____

Social Security Number _____ Employer _____

Insurance Company _____ Phone (_____) _____ Address _____

Do you have additional insurance? ___ Yes ___ No Name of Insured _____ Birthdate _____

Social Security Number _____ Relationship to Patient _____ Employer _____

Insurance Company _____ Phone (_____) _____ Address _____

INSURANCE ASSIGNMENT AND RELEASE

I certify that I (or my dependent) is covered by insurance with (**Insurance Company(ies)**) _____ and I assign directly to Dr. Glenn T. Swindle, Jr. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. I also understand that Dr. Swindle is not contracted (in network) with my insurance company.

The above-named doctor may use my (or my dependants) health care information and may disclose such information to the above-named Insurance Company(ies) or their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services.

FINANCIAL AGREEMENT

I acknowledge that payment is due at the time of treatment, unless other arrangements are made in advance. I agree that parents, guardians or personal representatives are responsible for all fees and services rendered for the treatment of a minor/ child. I accept full financial responsibility for all charges for services or items provided to the patient or me. I understand that filing a claim with my insurance company does not relieve me from my responsibility for the payment of all charges.

Signature of patient, parent, or guardian _____ Relationship to patient _____

Printed name of patient, parent, or guardian _____ Date _____

DENTAL / MEDICAL HISTORY

Date _____

What is your main concern? _____ Date of last Dental visit _____ Date of last X-rays _____

Former Dentist _____ Phone (____) _____ Address _____

How often do you brush? _____ floss? _____ Do your gums bleed while brushing/flossing? _____

Please check and circle any that apply:

- Bad breath
- Bleeding gums
- Clicking or popping jaw
- Food collection between teeth
- Grinding/clinching teeth
- Bite your lip or cheek
- Prolonged bleeding after extraction
- Loose teeth or broken filling
- Periodontal treatment
- Sensitivity to cold, hot, sweets
- Sensitivity to biting
- Sores/growths in/near your mouth
- Instruction on correct oral hygiene
- Have (had) orthodontic work
- Pain (teeth, joint, ear, side of face)
- Head, neck or jaw injuries
- Swelling
- Difficulty opening/closing or chewing
- Frequent headaches
- Instruction on the care of your gums
- Have had difficult extractions

Physician's Name _____ Phone (____) _____ Date of last visit _____

Have you had any serious illness or operations?(when/what) _____

Have you had a blood transfusion? __ yes __ no Responded adversely to medical/dental treatment? __ yes __ no

Have you taken any of the group of drugs called Bisphosphonates (Fosamax, Bonivia, Actonel, Zometa)? __ yes __ no

Do you have any drug allergies or have you had an adverse reaction to dental anesthetic/anesthesia? __ yes __ no

If so, what? _____

Are you taking any medication (prescription, over-the-counter, or herbal)? __ yes __ no

If so, what? _____

Do you have to pre-medicate before a dental visit? __ yes __ no If yes, what medication? _____

(Women): Are you pregnant? __ yes __ no Nursing? __ yes __ no Taking birth control pills? __ yes __ no

Please check and circle all that apply:

- Anemia
- Arthritis, Rheumatism
- Scarlet fever
- Artificial joints, heart valves, screws
- Asthma
- Cancer, Leukemia
- Chemotherapy
- Chemical dependency
- Circulatory problems
- Cough, Emphysema
- Diabetes
- Epilepsy / convulsions
- Fainting / seizures
- Sinus problems
- Blood disease
- Hepatitis, Jaundice or liver disease
- Headaches
- Heart murmur
- Kidney disease
- Abnormal bleeding, hemophilia
- HIV/ AIDS
- Mitral valve prolapse
- Pacemaker
- High/Low blood pressure
- Psychiatric care
- Nervous problems
- Weight loss/gain
- Radiation treatment
- Tobacco habit
- Thyroid problems
- Tuberculosis
- Swelling (glands, feet, ankles)
- Stroke or heart attack
- Circulatory problems
- Ulcer
- Latex allergy

Is there anything else we should know about your medical history? __ yes __ no

If so, what? _____

I certify that the above information is accurate and complete to the best of my knowledge. I am aware that this information is critical to my treatment.

Signature _____ Date _____

