Harbortown DENTAL

David H. Swain, DDS

Patient Information

Name_____ Preferred Name _____ Birthdate _____

Street Address_____ City _____ State _____ Zip_____

Cellular Phone # _____ Home Phone # _____ Work Phone # _____

Email _____

Social Security # _____

Emergency Contact_____ Relation _____ Phone# _____

Whom May We Thank For Referring You _____

All information provided on this form is for our records only and will be kept confidential.

Dental Insurance Information

Name of Subscriber_____Relationship to Patient_____

Name of Employer_____ Employer Phone # _____

Birthdate_____ Social Security # _____

Insurance Co._____ Subscriber ID_____ Group#_____

Insurance Co. Address_____ City_____ State_____ Zip _____

Do you have a secondary dental insurance? Yes / No

If (yes), Name of insurance Co. _____ Subscriber ID _____ Group #_____

Patient Dental History

Name and Location of previous Dentist_____ Date of Last Exam_____

Circle yes or no if any of the following apply.

Do your gums bleed while brushing or flossing? .....Yes / No

Are your teeth sensitive to hot or cold? .....Yes / No

Are your teeth sensitive to sweet or sour? .....Yes /No

Are any of your teeth causing pain? .....Yes / No

Do you have any sores or lumps in or near your mouth? ...Yes / No

Have you had any head, neck or jaw injuries? .....Yes / No

Do you wear dentures or partials? .....Yes / No

Do you have frequent headaches? .....Yes / No

Do you clench or grind your teeth? .....Yes / No

Do you bite your lips or cheeks frequently? .....Yes / No

Have you ever had any difficult extractions? .....Yes / No

Have you ever had any prolonged bleeding after an extraction? ....Yes / No

Have you had any orthodontic treatment? .....Yes / No

Have you ever received oral hygiene instructions? .....Yes / No

Have you ever experienced any of the following in your jaw?

1) Difficulty Opening or Closing? ...Yes / No 2) Difficulty Chewing? ....Yes / No 3)Pain? ....Yes / No 4) Clicking? ...Yes / No

Patient Medical History

Primary Care Physician_____ Office Phone #_____ Date of Last Exam_____

Are you under medical care right now? ...Yes / No
If yes please list reason _____

Have you ever been hospitalized for any surgical operations or serious illness?...Yes / No
If (yes), please explain:

_____

_____

Are you taking any medication(s) including non-prescription?...Yes / No
If (yes), please explain:

_____

_____

_____

Do you use tobacco? .....Yes No

Have you ever taken Fen-Phen/Redux?.....Yes / No

Do you use controlled substances? ....Yes No
If (yes) please list_____

ALLERGIES

Are you allergic to or have you had any reactions to the following?

Local Anesthetic (.eg. Novocaine)....Yes / No
Penicillin or other Antibiotics .....Yes / No
Sulfa Drugs.....Yes / No
Latex / Rubber.....Yes / No

Barbiturates/Sedative .....Yes / No
Aspirin .....Yes / No
Codeine .....Yes / No
Any Metals (e.g. nickel, mercury, etc.) ...Yes / No

Please list all other known allergies:

_____

_____

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

High Blood Pressure.....Yes / No	Epilepsy/Convulsions.....Yes / No	Cancer.....Yes / No
Chest Pain/Angina.....Yes / No	Fainting/Seizures.....Yes / No	Radiation Therapy.....Yes / No
Heart Attack.....Yes / No	Blood Disorders/Bleeding Problems..Yes / No	Chemotherapy.....Yes / No
Heart Murmur.....Yes / No	Anemia.....Yes / No	Tuberculosis.....Yes / No
Mitral Valve Prolapse.....Yes / No	Kidney Disease.....Yes / No	Emphysema.....Yes / No
Stroke.....Yes / No	Diabetes.....Yes / No	Respiratory Problems.....Yes / No
Pacemaker.....Yes / No	Hepatitis/Jaundice.....Yes / No	Asthma.....Yes / No
Rheumatic Heart Disease.....Yes / No	Liver Disease.....Yes / No	Glaucoma.....Yes / No
Rheumatic Fever.....Yes / No	AIDS/HIV.....Yes / No	Arthritis.....Yes / No
Heart Disease.....Yes / No	Thyroid Problems.....Yes / No	Joint Replacement/Implant..Yes /No

Other:_____

_____

_____

Women Only:

Are you pregnant or think you may be pregnant?.....Yes / No

Are you nursing?.....Yes / No

Are you taking any oral contraceptives?.....Yes / No

Authorization and Release

I certify that I have read and understand the above information. The above questions have been answered accurately.

Patient Signature:_____ Date:_____

Doctors Signature:_____ Date:_____

Harbortown Dental

Appointment Cancellation Policy

As part of our patient family we want you to know that we understand that everyone's time is valuable. Dr. Swain and our Hygienist's want to be available for your needs and the needs of all our patients. We do understand that schedules can change due to unforeseen occurrences, and when this happens we respectfully request for 48 business hours' notice for any cancellations or changes to your appointment. This will allow for the schedule to run smoothly and allow us to get you re-appointed.

Thank you for being part of our valuable patient family and for your understanding and cooperation.

Patient signature _____

Date: _____

Harbortown Dental

Understanding Your Insurance

- I understand that my insurance is an agreement between my insurance company and myself.

- I understand that I am responsible for the balance of my account regardless of what the insurance will cover.

- I assign dental benefit payments to be paid directly to Dr. Swain from my insurance company.

- I give permission to my dentist to use composite (white) filling material when applicable. I understand that my insurance company may only pay for the cost of an amalgam (silver) filling and that I will be responsible for any remaining balance.

Patient Name: _____

Patient Signature: _____

Date: _____

Harbortown
DENTAL

Dr. Swain DDS, 300 Franklin Ave, Grand Haven, MI 49417 | Phone: 616-842-4480 | Fax: 616-842-0567

Acknowledgement of Receipt of Notice of Privacy Practices

I have received a copy of this office's Notice of Privacy Practices.

Print Name : _____

Signature : _____ Date : _____

I, _____ give my permission to this office to share my information with the following person(s)

Name & Phone # of person(s)

_____

_____

_____

Signature of Patient : _____ Date : _____

~You may refuse to sign this acknowledgement~

Specify reason(s) of refusal

_____

_____

_____

Web: harbortowndental.com | Email: info@harbortowndental.com