WILLIAM H. SWEARINGEN, D.D.S.

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PATIENT: Please complete the following confidential information

Date _____

Name _____

Nickname _____

Address _____

City _____ State _____ Zip _____

Home Phone # _____ Cell # _____

E-Mail Address _____

Birthdate _____ Age _____ Sex M ☐ F ☐

Social Security # _____

Married _____ Single _____ Divorced _____ Widowed _____

ADDRESS CHANGE

1) Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell # _____

2) Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell # _____

INSURANCE

Primary Subscriber _____

Date of Birth _____

Social Security # _____

Insurance Co. _____

Employer _____

Group # _____

Secondary Subscriber _____

Date of Birth _____

Social Security # _____

Insurance Co. _____

Employer _____

Group # _____

ACCOUNT INFORMATION

Person responsible for account

_____

CA Driver's License # _____

Address _____

(IF DIFFERENT FROM ABOVE)

City _____ State _____ Zip _____

Home Phone # _____ Cell # _____

E-mail Address _____

YOUR:

Name _____

Occupation _____

Employer _____

Business Address _____

City _____ State _____ Zip _____

Business Telephone _____ Ext. _____

GETTING TO KNOW YOU

Is another member of your family, or relative a patient at our office? _____

Referred to us by _____

Person to contact for emergency _____

_____

Phone # 1 _____ Phone # 2 _____

YOUR SPOUSE

Name _____

Occupation _____

Employer _____

Business Address _____

City _____ State _____ Zip _____

Business Telephone _____ Ext. _____

Please Complete Reverse Side➔

HEALTH HISTORY

1. Do you have a primary care Physician? If so please provide information below
   Physician's Name _____ YES NO
   Address _____ Phone # _____
2. Are you in good health? . . . . . YES NO
3. Have you been hospitalized or had a serious illness within the past 5 years? . . . . . YES NO
4. Have you had any recent surgeries? . . . . . YES NO
5. Are you now taking any medication, drugs or pills? . . . . . YES NO
   If yes please list those drugs: _____
   _____
   _____
6. Are you allergic or have you reacted adversely to any of the following medications: *(Mark appropriate box with an X)*

	YES	NO		YES	NO		YES	NO
Aspirin	☐	☐	Sulfites (preservatives)	☐	☐	Penicillin	☐	☐
Tylenol	☐	☐				Erythromycin	☐	☐
Advil/motrin	☐	☐	Nitrous Oxide	☐	☐	Tetracycline	☐	☐
Codeine	☐	☐	Local Anesthetic	☐	☐	Sulfa	☐	☐
Darvocette	☐	☐	Novocain	☐	☐	Other Antibiotics	☐	☐
Percodan	☐	☐	Xylocaine	☐	☐			

7. Are you aware of being allergic to any other medication or substance? . . . . . YES NO
   If yes, please list: _____
8. Have you ever had: *(Mark appropriate box with an X)*

	YES	NO		YES	NO		YES	NO
Heart Condition	☐	☐	Asthma	☐	☐	Glaucoma	☐	☐
Heart Attack	☐	☐	Thyroid Condition	☐	☐	Tuberculosis	☐	☐
Heart Murmur	☐	☐	Bleeding Problems	☐	☐			
Rheumatic Fever	☐	☐	Anemia	☐	☐	Kidney Disease	☐	☐
Stroke	☐	☐	Blood Transfusions	☐	☐	Hepatitis *(Liver Disease)*	☐	☐
High Blood Pressure	☐	☐	Ulcers	☐	☐	Convulsions	☐	☐
Diabetes	☐	☐	Cancer	☐	☐	Epilepsy	☐	☐
Artificial Joint Placed	☐	☐	Radiation Therapy	☐	☐	AIDS or Exposure	☐	☐
Arthritis	☐	☐	Chemotherapy	☐	☐	Sexually Transmitted Disease	☐	☐

9. Do you smoke? If yes, how much? _____ YES NO
10. Do you have any disease, condition or problem not listed above that you think we should know about? . . . . . YES NO
    If yes explain: _____
11. **FOR WOMEN ONLY:** Are you pregnant? If yes what month? _____

CONSENT:

The undersigned hereby authorizes the Doctor to take radiographs, study models, photographs or any other diagnostic aids deemed appropriate by the Doctor to make a thorough diagnosis of the patients dental needs. The undersigned, upon being duly informed by the Doctor, also authorizes the Doctor to perform any and all forms of treatment, medication and therapy that may be indicated in connection with the undersigned or any person for whom the undersigned is responsible (I.e., dependent child), and further authorizes and consents that the Doctor choose and employ such assistance as he deems fit. The undersigned also understands the use of anesthetic agents embodies a certain risk – minor though it may be.

Signature _____ **Date** _____

If signing for child, your relationship to child _____

HEALTH HISTORY UPDATE

I have reviewed my original health history above and certify that it is accurate except for the changes indicated below:

Date _____ BP _____ Pulse _____ Date _____ BP _____ Pulse _____

Changes _____ Changes _____

Signature _____ Signature _____

Date _____ BP _____ Pulse _____ Date _____ BP _____ Pulse _____

Changes _____ Changes _____

Signature _____ Signature _____