Serene Smiles Dentistry
Dr. Rachel J. Swart, D.D.S., PA
600 Gathering Park Circle, Suite 102 Cary, NC 27519 *Office: 919-460-7025* *Fax: 919-460-8808* *info@serenesmiles.com*

Date: _____

PATIENT INFORMATION

Name: Last First Middle Preferred **Date of Birth:**

Home Phone: ( ) **Work Phone:** ( ) **Cell Phone:** ( ) ☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other

Address: Street Apt. # City State Zip Code

Employer: **Occupation:** **SSN:** **Email Address:**

Emergency Contact: Name Relationship: **Home Phone:** ( ) **Work Phone:** ( )

HEALTH INFORMATION

Physician Name: **City/ State:** **Phone:** ( )

Date of last visit: **Reason For visit:**

List any prior surgeries:

Have you been admitted to a hospital or needed emergency care during the past 5 years? ☐ Yes ☐ No
If yes, please explain:

Are you now under the care of a physician? ☐ Yes ☐ No
If yes, please explain:

Do you have any current health problems? ☐ Yes ☐ No
If yes, please explain:

How did you hear about us?

Do you, or have used, any form of tobacco? ☐ Yes ☐ No

For women: Are you, or could you be pregnant? ☐ Yes ☐ No
Are you currently nursing/breastfeeding? ☐ Yes ☐ No

Have you ever taken a bisphosphonate medication for osteoporosis? ☐ Yes ☐ No

Are you allergic to, or had an adverse reaction for any of the following? (please circle) ☐ Yes ☐ No
LATEX ASPIRIN PENICILLIN ERYTHROMYCIN

Please list any other medication or substance that you are allergic to:

Do you use recreational drugs? ☐ Yes ☐ No
If yes, please explain:

Do you use a CPAP machine? ☐ Yes ☐ No

Are you currently taking any medications? If yes, please list below:
Medication Dosage Reason

_____
_____
_____
_____

Have you had or been treated by a physician for:

Damaged Heart Valves, Mitral Valve Prolapse, or Artificial Heart Valves? ☐ Yes ☐ No
Rheumatic Fever, Rheumatic Heart Disease, or Congenital Heart Problems? ☐ Yes ☐ No
Have you ever been advised to pre-medicate prior to dental treatment? ☐ Yes ☐ No
Artificial Joints/Replacements? ☐ Yes ☐ No
High Blood Pressure? ☐ Yes ☐ No
Cancer, Tumors, or Growths? ☐ Yes ☐ No
AIDS, AIDS related conditions, or tested HIV positive? ☐ Yes ☐ No
Diabetes? ☐ Yes ☐ No

Circle any conditions listed below that you have, or have had:

Alcoholism	Chemotherapy	Hepatitis A/B	Radiation Therapy
Anemia	Emphysema	Herpes	Sleep Apnea
Angina	Epilepsy/Seizures	Kidney Disease	Sinus Problems
Arthritis	Fainting	Liver Disease	Stroke
Asthma	Glaucoma	Mental Disorders/Delays	Thyroid Disease
Blood Disorder	Hay Fever	Osteoporosis	Tuberculosis (TB)
		Pacemaker	Ulcers

Any other medical conditions? _____

_____

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DENTAL INFORMATION

When was your last dental visit?	**Name of Previous Dentist:**	
What is your main dental concern?	**City/ State:**	**Phone:** ( )

Have you had dental x-rays taken within the past 2 years? ☐ Yes ☐ No ☐ Don't Know
Are your teeth sensitive to hot, cold, sweets, or biting pressure? ☐ Yes ☐ No ☐ Don't Know
Would you like your smile to look better or different? ☐ Yes ☐ No ☐ Don't Know
Are you aware of grinding or clenching your teeth? ☐ Yes ☐ No ☐ Don't Know
Do you have pain in your jaw joints or have frequent headaches? ☐ Yes ☐ No ☐ Don't Know
Have you ever had any injuries to your teeth or jaws? ☐ Yes ☐ No ☐ Don't Know
Have you ever had braces on your teeth? ☐ Yes ☐ No ☐ Don't Know
Have you ever been treated for gum disease or had periodontal surgery? ☐ Yes ☐ No ☐ Don't Know
Does food get stuck between your teeth? ☐ Yes ☐ No ☐ Don't Know
Do you wear any oral appliances (retainers, night guard, etc.)? ☐ Yes ☐ No ☐ Don't Know
Are you anxious or fearful about dental visits? ☐ Yes ☐ No ☐ Don't Know
If yes, please explain: _____

How often do you brush? _____ How often do you use dental floss? _____

INSURANCE INFORMATION

Primary Insurance Company Name & Phone Number:		**Employer:**
Name of Policy Holder: Last First		**Policy Holder's Birth Date:**
Insured SSN/ID #:	**Group #:**	**Patient's relationship to insured:** ☐ Self ☐ Spouse ☐ Child ☐ Other
Secondary Insurance Company Name & Phone Number:		**Employer:**
Name of Policy Holder: Last First		**Policy Holder's Birth Date:**
Insured SSN/ID #:	**Group #:**	**Patient's relationship to insured:** ☐ Self ☐ Spouse ☐ Child ☐ Other

CONSENT FOR SERVICES

- To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health I will inform the doctor at the next appointment.
- I authorize the release of any medical information necessary to process claims.
- I understand that I am personally responsible for all professional fees at the time service is rendered. In the event of default, the undersigned agrees to pay all costs of collection including any reasonable attorney's fees and court costs.

_____ Date: _____
Signature of patient, parent or guardian

_____ Relationship: _____
If parent/guardian, please print name

_____ Date: _____
Doctor Signature