Sewee Dental Care

Thank you for selecting our dental healthcare team!
We will strive to provide you with the best possible dental care.
To help us meet all of your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us –
We will be happy to help!

Date:_____ S.S. # _____

Patient Information (CONFIDENTIAL)

Name _____ Nickname _____ Birthdate _____ Home Phone _____
Address _____ City _____ State _____ Zip _____
Email Address _____ Cell Phone _____
Best Method of Contact _____
Check Appropriate Box ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Student School/ College _____ City _____ State _____ ☐ Full Time ☐ Part Time
Patient's or Parent's Employer _____ Work Phone _____
Business Address _____ City _____ State _____ Zip _____
Spouse or Parent Name _____ Whom May We Thank for Referring You? _____

Person to Contact in Case of Emergency _____ Phone _____
Name of Person Responsible for this Account _____ Relationship to Patient _____
Address _____ Phone _____
_____ Birthdate _____
Employer _____ S.S.# _____
Is this Person Currently a Patient in Our Office? ☐ Yes ☐ No

PLEASE PRESENT INSURANCE CARD TO THE FRONT DESK

Patient Dental History

Name and Location of Previous Dentist _____ Date of Last Exam _____

	Yes	No
1. Do your gums bleed while brushing or flossing?	☐	☐
2. Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
3. Are your teeth sensitive to sweet or sour liquids/foods?		
4. Do you feel pain to any of your teeth?	☐	☐
5. Do you have any sores or lumps on/near your mouth?	☐	☐
6. Have you had any head, neck, or jaw injuries?	☐	☐
7. Have you ever experienced any of the following problems in your jaw?		
Clicking	☐	☐
Pain (joint, ear, side of face)	☐	☐
Difficulty in opening or closing	☐	☐
Difficulty in chewing	☐	☐
8. Do you have frequent headaches?	☐	☐
9. Do you clench or grind your teeth?	☐	☐
10. Do you bite your lips or cheeks frequently?	☐	☐
11. Have you ever had any difficult extractions in the past?	☐	☐
12. Have you ever had any prolonged bleeding following extractions?	☐	☐
13. Have you had any orthodontic treatment?	☐	☐
14. Do you wear dentures or partials?	☐	☐
If yes, date of placement _____		
15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	☐	☐
16. Do you like your smile?	☐	☐

(OVER PLEASE)

Patient Medical History

Physician _____ Office Phone _____ Date of Last Exam _____

	Yes	No
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness within the past 5 years? If so, please explain _____ _____	☐	☐
3. Are you taking any medication(s) including non-prescription medicine? If yes, what medication(s) are you taking? _____ _____ _____ _____ _____	☐	☐
4. Do you use tobacco?	☐	☐
5. Do you use controlled substances?	☐	☐
6. Are you allergic to, or have you had any reactions to the following?		
Local Anesthetics……	☐	☐
Penicillin or any other Antibiotics……	☐	☐
Sulfa Drugs……	☐	☐
Sedatives……	☐	☐
Iodine……	☐	☐
Aspirin……..	☐	☐
Any Metals (e.g. nickel, mercury, etc.)……	☐	☐
Latex Rubber……	☐	☐
Other (please list)…….. _____ _____	☐	☐
7. Have you ever been told that you need to be premedicated for any dental treatment? Explain _____ _____	☐	☐
8. Women only:		
a) Are you pregnant or think you may be pregnant?	☐	☐
b) Are you nursing?	☐	☐
c) Are you taking oral contraceptives?	☐	☐

9. Do you have, or have you had any of the following?	Yes	No
AIDS/HIV……...	☐	☐
Anemia…….	☐	☐
Arthritis……...	☐	☐
Back problems which keep you from fully reclining in chair…….	☐	☐
Bisphosponates – Fosamax/Boniva……	☐	☐
Cancer…….	☐	☐
Cardiac Pacemaker…….	☐	☐
Chest Pains…….	☐	☐
Diabetes……..	☐	☐
Digestive Problems……..	☐	☐
Epilepsy/Convulsions……..	☐	☐
Fainting/Seizures…….……	☐	☐
Frequently Tired…….	☐	☐
Glaucoma…….	☐	☐
Hay Fever / Allergies……..	☐	☐
Heart Attack / Trouble…….	☐	☐
Hepatitis / Jaundice…….	☐	☐
High Blood Pressure……..	☐	☐
Joint Replacement……..	☐	☐
If so, how long ago / date of surgery _____		
Liver Disease…….	☐	☐
Low Blood Pressure……	☐	☐
Mitral Valve Prolapse / Murmur……	☐	☐
Organ Transplant……	☐	☐
Other……..	☐	☐
Radiation Therapy…….	☐	☐
Recent Weight Loss……	☐	☐
Respiratory Problems……	☐	☐
Rheumatic Fever…….	☐	☐
Sexually Transmitted Disease…….	☐	☐
Stroke……...	☐	☐
Swollen Ankles……	☐	☐
Tuberculosis……	☐	☐

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release my information, including the diagnosis and the records, of any treatment or examination rendered to me or my child during the period of such dental care, to the third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insruance carrier may pay for less than the actual bill for services. I agree to be responsible for payment of all services rendered on behalf of me or my dependents.

X_____

Signature of patient (or parent if minor)