415 S. Main Street, Roxboro, NC 27573 – 336-599-4145 – info@swiftfamilydentistry.com

Welcome to Swift Family Dentistry!

We are thrilled to have you join our office and look forward to providing you with the highest quality care in a comfortable and friendly environment. You are our priority and we are look forward to getting to know you.

Out of Network Office

We are a fee for service dental practice and are not in network with any dental insurance providers. We will gladly help you file your insurance as an out of network provider as a courtesy. If you have insurance, we urge you to call to see if they allow you to visit an out of network office or you will be responsible for 100% of billed services.

New Patient Appointment Policy

We require a $100 nonrefundable deposit and submission of completed paperwork one week prior to your new patient appointment. This allows us enough time to track down old x-rays if needed and to secure your spot in our schedule as we have had an overwhelming number of last-minute cancellations or no shows for new patient appointments. These appointments consist of two hours of our schedule time. This $100 deposit will be credited towards the total of your first new patient appointment balance.

We also require on the day of the new patient appointment, the balance be paid in full regardless of if you have insurance or not (again, this total includes the $100 credit you have already paid). If you have insurance, we will submit as a courtesy and once we receive payment, we can either leave as a credit on your account or write you a refund check directly for any amount covered by insurance. For any future appointments, payment at the time of service will not be required. Instead, we will submit to insurance and once paid, bill you directly for any remaining balance.

Cancellation Policy

Our practice is dedicated to quality care and exceptional service. We spend extensive amounts of time preparing for your visit. Broken and missed appointments create scheduling problems for our entire team, as well as other patients. We require a minimum 24-hour notice to cancel or reschedule an appointment (excluding new patient appointments-see that policy above) so that we can make every effort to accommodate other patients. Failure to provide this 24-hour notice will result in a $50 fee for every hour of allotted time that was cancelled. You receive automated reminders 2 weeks out, 1 week out, and final confirmation 24 hours before so if you are needing to reschedule, we ask for you to let us know ASAP.

Please reach out should you have any questions and again, we look forward to seeing you soon!

Brian Swift, DDS
Swift Family Dentistry

New Patient Registration

Patient Information

Name: _____ Birthday: _____ SS#:_____

Nickname or Preferred name:_____

Sex: Male_____ Female_____

Is patient a minor?: Yes _____ No _____

Address: _____

City: _____ State:_____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email address: _____

Best way to reach you for appointment reminders? Text message: ____ Phone Call: ____ Email: ____

Whom may we thank for referring you?: _____

Emergency Contact: _____Relationship: _____ Phone: _____

Name of person responsible for account (if different from above): _____

Address (if different from above): _____

Phone (if different from above): _____

Primary Dental Insurance

Subscriber name (name of person that holds policy): _____

Relationship to patient: _____

Birthday: _____ SS#: _____ ID#: _____

Employer: _____ Work phone: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Insurance Company: _____ Group #: _____

Address: _____ City: _____ State: _____ Zip: _____

New Patient Registration

Secondary Dental Insurance (if applicable)

Subscriber name (name of person that holds policy): _____

Relationship to patient: _____

Birthday: _____ SS#: _____ ID#: _____

Employer: _____ Work phone: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Insurance Company: _____ Group #: _____

Address: _____ City: _____ State: _____ Zip: _____

Notice of Privacy Practices Acknowledgement

I acknowledge that I have read the "Notice of Privacy Practices" and a copy is available upon my request.

_____ _____

Patient or Representative Signature Date

Relationship to patient: Self ☐ Parent ☐ Spouse ☐ Other _____

Authorization (if applicable)

Below are the people that have access to my medical/dental records and information to schedule appointments. We will not discuss your information with anyone without specific signed authorization. I hereby authorize the following person(s) to communicate with Dr. Brian Swift and staff regarding all pertinent aspects of my medical/dental care.

_____ _____

Print name Relationship

_____ _____

Print name Relationship

Authorization and Release

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my dentist if I, or my minor child, ever have a change in health.

I certify that I, and/or my dependent have insurance coverage with _____(name of insurance company) and assign directly to Dr. Brian Swift all insurance benefits, if any, otherwise payable to me for services rendered. I UNDERSTAND THAT I AM FULL FINANCIALLY RESPONSIBLE for all charges, whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above named dentist may use my healthcare information and may disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services

_____ _____

Signature of patient, parent, or guardian Date

_____ _____

Please print name of patient, parent of guardian Relationship

New Patient Registration

Dental History

Do your glums bleed when you floss? ☐Yes ☐No

Are your teeth sensitive to hot, cold, sweets or pressure? ☐Yes ☐No

Is your mouth dry?☐Yes ☐No

Have you ever had problems with previous dental treatment?☐Yes ☐No

Do you have tap or well water? ☐Tap ☐Well

Are you currently experiencing dental pain?☐Yes ☐No

Do you notice clicking/popping/discomfort at your TMJ/jaw joint?☐Yes ☐No

Do you brux/grind/clench your teeth?☐Yes ☐No

Do you have sores or ulcers?☐Yes ☐No

Have you ever had serious trauma/injury to your head or mouth?☐Yes ☐No

Please explain: _____

Have you ever experienced dizziness or fainting from a dental procedure?☐Yes ☐No

How many times a day do you brush? _____

How many times a day to you floss? _____

Do you have an electric toothbrush?☐Yes ☐No

When was your last dental visit that you recall? _____

Name of dental office? _____ Location? _____

Do you recall the last time you had dental xrays? _____

What is the reason for your visit today?

_____

_____

New Patient Registration

Medical History

Please mark YES or NO if you have ever been diagnosed with any of the following:

Artificial heart valve	☐ Yes	☐ No
Joint replacement	☐ Yes	☐ No
Cardiovascular/Heart disease	☐ Yes	☐ No
Atril fibilration (AFIB)	☐ Yes	☐ No
Angina	☐ Yes	☐ No
Heart Attack	☐ Yes	☐ No
Heart murmur	☐ Yes	☐ No
Congenital heart problem	☐ Yes	☐ No
Endocarditis	☐ Yes	☐ No
Rheumatic fever	☐ Yes	☐ No
Mitral valve prolapse	☐ Yes	☐ No
Heart surgery	☐ Yes	☐ No
Stroke	☐ Yes	☐ No
Low blood pressure	☐ Yes	☐ No
High blood pressure	☐ Yes	☐ No
Pacemaker	☐ Yes	☐ No
Abnormal/excess bleeding	☐ Yes	☐ No
Anemia	☐ Yes	☐ No
Hemophilia	☐ Yes	☐ No
AIDS or HIV	☐ Yes	☐ No
Arthritis (Osteo or Rheumatoid)	☐ Yes	☐ No
Asthma	☐ Yes	☐ No
Bronchitis	☐ Yes	☐ No
Emphysema/COPD	☐ Yes	☐ No
Diabetes (Type I or Type II)	☐ Yes	☐ No
Eating disorder	☐ Yes	☐ No
GI disease	☐ Yes	☐ No
Reflux/heart burn	☐ Yes	☐ No
Thyroid problems	☐ Yes	☐ No
Stroke	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No

Hepatitis/Liver disease	☐ Yes	☐ No
Epilepsy	☐ Yes	☐ No
Fainting or Seizures	☐ Yes	☐ No
Neurologic disorders	☐ Yes	☐ No
Sleep disorders	☐ Yes	☐ No
Mental health disorders	☐ Yes	☐ No
Kidney problems	☐ Yes	☐ No
Osteoporosis	☐ Yes	☐ No
Sexually transmitted disease	☐ Yes	☐ No

Other conditions not listed above:

_____

_____

_____

_____

Allergies (Please select any applicable)

I have no known allergies – please check here ☐

Penicillin	☐ Yes	☐ No
Sulfa drugs	☐ Yes	☐ No
Aspirin	☐ Yes	☐ No
Opioids	☐ Yes	☐ No
Local anesthetics/Epinipherine	☐ Yes	☐ No
Metals	☐ Yes	☐ No
Latex	☐ Yes	☐ No

Other (list or explain):

_____

_____

_____

_____

If you selected "Yes" to Artificial Heart Valve or Joint Replacement above, please list below what joints have been replaced, when they were replaced, and if you were told you needed to take antibiotics prior to dental appointments:

_____

_____

_____

_____

New Patient Registration

Medical History (continued)

Have you ever taken bisphosphonates (Fosamax, Boniva, Prolia, XGEVA, etc)? ☐Yes ☐No
When did you take these and for how long? _____

Are you currently pregnant?☐Yes ☐No
Number of weeks? _____

Do you use tobacco products?☐Yes ☐No
Amount:

Do you drink alcohol? ☐Yes ☐No
Amount:

Do you use recreational drugs? ☐Yes ☐No
Amount:

Have you been hospitalized in past 5 years?☐Yes ☐No Why? _____

Please list all current medications and dosages below. Include prescription, OTC, and supplements.

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Is there anything not covered by this form that you would like Dr. Swift to be aware of?

_____

_____

By signing here, I certify that I am the patient, or representative of the patient authorized to provide the information on this form. I understand all questions on this form and this information has been filled out with no omissions. I will not hold Swift Family Dentistry responsible for complications arising from omissions or errors on this form

Signature: _____ Date: _____

Dr. Brian Swift, DDS
415 South Main Street
Roxboro, NC 27573
Ph: (336) 599-4145
Fax: (336)599-4301

Dental Release Records

Date: _____

_____ _____
Patient Name Date of Birth

_____
Patient Address

_____
Patient Phone

This patient is requesting that a copy of the dental treatment records and x-rays be released from the following dental office:

_____

_____

_____

Phone: _____ Fax: _____

Please send this information to:
Dr. Brian Swift, DDS
415 South Main Street
Roxboro, NC 27573
Email: info@swiftfamilydentistry.com
Fax: (336)599-4301
Ph: (336) 599-4145

_____ _____
Signature of Patient or Legal Guardian Date