



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 look forward to getting to know you.

Out of Network Office

We are a fee for service dental practice and are not contracted (“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

Payment in full is required on the day of your new patient appointment regardless of insurance coverage. If you have dental insurance, we will submit your claim as a courtesy. Once payment is received from your insurance company, we will either leave the amount as a credit on your account or issue a refund check. 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 at least 24 hour’s notice will result in a \$50 fee per hour of reserved appointment time. 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!

A handwritten signature in black ink that reads "Brian Swift". The signature is fluid and cursive, with the first name "Brian" and last name "Swift" clearly legible.

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 gums 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 do 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	Hepatitis/Liver disease	Yes	No
Joint replacement	Yes	No	Epilepsy	Yes	No
Cardiovascular/Heart disease	Yes	No	Fainting or Seizures	Yes	No
Atrial fibrillation (AFIB)	Yes	No	Neurologic disorders	Yes	No
Angina	Yes	No	Sleep disorders	Yes	No
Heart Attack	Yes	No	Mental health disorders	Yes	No
Heart murmur	Yes	No	Kidney problems	Yes	No
Congenital heart problem	Yes	No	Osteoporosis	Yes	No
Endocarditis	Yes	No	Sexually transmitted disease	Yes	No
Rheumatic fever	Yes	No	Other conditions not listed above:		
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	Allergies (Please select any applicable)		
Abnormal/excess bleeding	Yes	No			
Anemia	Yes	No	I have no known allergies – please check here <input type="checkbox"/>		
Hemophilia	Yes	No			
AIDS or HIV	Yes	No	Penicillin	Yes	No
Arthritis (Osteo or Rheumatoid)	Yes	No	Sulfa drugs	Yes	No
Asthma	Yes	No	Aspirin	Yes	No
Bronchitis	Yes	No	Opioids	Yes	No
Emphysema/COPD	Yes	No	Local anesthetics/Epinipherine	Yes	No
Diabetes (Type I or Type II)	Yes	No	Metals	Yes	No
Eating disorder	Yes	No	Latex	Yes	No
GI disease	Yes	No	Other (list or explain):		
Reflux/heart burn	Yes	No	_____		
Thyroid problems	Yes	No	_____		
Stroke	Yes	No	_____		
Glaucoma	Yes	No	_____		

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