PATIENT INFORMATION

NAME *(First)* *(MI)* *(Last)*			HOME PHONE
ADDRESS *(No.)* *(Street)* *(City)* *(State)* *(Zip)*			CELL PHONE
BIRTH DATE *(Month)* *(Date)* *(Year)* / /	AGE:	SEX ❑ Male ❑ Female	WORK PHONE
SOCIAL SECURITY #	DRIVERS LICENSE # & STATE	MARITAL STATUS S M D W	E-MAIL
EMPLOYER	OCCUPATION		

SPOUSE'S NAME		WORK PHONE	CELL PHONE
If the patient is a minor please complete the boxes to the right.	FATHERS NAME	HOME PHONE	WORK PHONE
	MOTHERS NAME	HOME PHONE	WORK PHONE

RESPONSIBLE AGENT **This is the person responsible for payment of this account, as such all bills will be sent here.**

NAME *(First)* *(MI)* *(Last)*	HOME PHONE	WORK PHONE
BILLING ADDRESS *(No.)* *(Street)* *(City)* *(State)* *(Zip)*	RELATIONSHIP TO PATIENT	SOCIAL SECURITY #

EMERGENCY INFORMATION

NAME OF NEAREST RELATIVE NOT LIVING WITH YOU	HOME PHONE	RELATIONSHIP TO PATIENT

REFERRAL INFORMATION **Whom may we thank for referring you to our practice?**

❑ The Phone Book	❑ My insurance Company	❑ Internet Search	❑ Business Sign	❑ Print Ad
❑ Practice Website	❑ Another Patient Name____			
❑ Practice Blog	❑ Other (Please Specify) ____			

SERVICES **So we can best serve you, tell us what services you are interested in discussing: (Check all that apply)**

❑ Replacing Silver Fillings	❑ Teeth Whitening	❑ Replacing Missing Teeth
❑ Porcelain Veneers or Crowns	❑ Straighter Teeth	❑ Other (Please Specify)______________________

____ ____

Signature of patient or Responsible party **If responsible agent, relationship to patient**

____

Date

FOR OFFICE USE ONLY -- ANNUAL REVIEW & DATE TRACKING

Review Date ____________	Review Date __________	Review Date ____________

CONSENT TO PROCEED

I authorize Dr. Swenson and/or such associates or assistants as he may designate to perform those procedures as may be deemed necessary or advisable to maintain my dental health or the dental health of any minor or other individual for which I have responsibility, including arrangement and/or administration of any sedative (including nitrous oxide), analgesic, therapeutic, and/or other pharmaceutical agent(s), including those related to restorative, palliative, therapeutic or surgical treatments.

I understand that the administration of local anesthetic may cause an untoward reaction or side effects, which may include, but are not limited to bruising, hematoma, cardiac stimulation, muscle soreness, and temporary or rarely, permanent numbness. I understand that occasionally needles break and may require surgical retrieval. Occasionally drops of local anesthetic may contact the eyes and facial tissues and cause temporary irritation.

I understand that as part of the dental treatment, including preventive procedures such as cleanings and basic dentistry, including fillings of all types, teeth may remain sensitive or even possibly quite painful both during and after completion of treatment. Dental materials and medications may trigger allergic or sensitivity reactions.

After lengthy appointments, jaw muscles may also be sore or tender. Holding one's mouth open can, in a predisposed patient, precipitate a TMJ disorder. Gums and surrounding tissues may also be sensitive or painful during and/or after treatment. Although rare, it is also possible for the tongue, cheek or other oral tissues to be inadvertently abraded or lacerated (cut) during routine dental procedures. In some cases, sutures or additional treatment may be required.

I understand that as part of dental treatment items including, but not limited to crowns, small dental instruments, drill components, etc. may be aspirated (inhaled into the respiratory system) or swallowed. This unusual situation may require a series of x-rays to be taken by a physician or hospital and may, in rare cases, require bronchoscopy or other procedures to ensure safe removal.

I understand the need to disclose to the dentist any prescription drugs that are currently being taken or that have been taken in the past, such as Phen-Fen. I understand that taking the class of drugs prescribed for the prevention of osteoporosis, such as Fosamax, Boniva or Actonel, may result in complications of non-healing of the jaw bones following oral surgery or tooth extractions.

I do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any, which may be associated with general preventive and operative treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit or the benefit of my minor child or ward. I acknowledge that the nature and purpose of the foregoing procedures have been explained to me if necessary and I have been given the opportunity to ask questions.

Patient Name:____

Signature:____ **Date:**__________________
(Patient, legal guardian or authorized agent of patient)

Witness:____ **Date:**__________________