

# Welcome

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 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: \_\_\_\_\_ Patient I.D. \_\_\_\_\_  
(for office use)

### Patient Information (CONFIDENTIAL)

Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_  
Cell Phone \_\_\_\_\_ Email Address \_\_\_\_\_  
Check Appropriate Box:     Minor     Single     Married     Divorced     Widowed     Separated  
If Student, Name of School/College \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ FT    PT  
Patient's or Parent's Employer \_\_\_\_\_ Work Phone \_\_\_\_\_  
Business Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Whom may we thank for referring you? \_\_\_\_\_  
Person to contact in case of emergency \_\_\_\_\_ Phone \_\_\_\_\_

### Responsible Party

Name of person responsible for this account? \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Address \_\_\_\_\_ Home Phone \_\_\_\_\_  
Driver's License# \_\_\_\_\_ Birthdate \_\_\_\_\_  
Employer \_\_\_\_\_ Work Phone \_\_\_\_\_ SSN# \_\_\_\_\_  
Is this person currently a patient in our office?    Yes    No

### Insurance Information

Name of insured \_\_\_\_\_ Relationship to patient \_\_\_\_\_  
Birthdate \_\_\_\_\_ Social Security \_\_\_\_\_ Work Phone \_\_\_\_\_  
Name of employer \_\_\_\_\_ Work Phone \_\_\_\_\_  
Address of employer \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Ins Co. Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

### Patient Dental History

	Yes	No
1. Do your gums bleed while brushing or flossing?.....	<input type="radio"/>	<input type="radio"/>
2. Do you clench or grind your teeth? .....	<input type="radio"/>	<input type="radio"/>
3. Have you ever had any difficult extraction in the past? .....	<input type="radio"/>	<input type="radio"/>
4. Do you wear dentures or partials? .....	<input type="radio"/>	<input type="radio"/>
If yes, date of placement _____		
5. How do you feel about getting and maintaining a healthy mouth? .....	<input type="radio"/>	<input type="radio"/>
_____		
_____		
6. How do you feel about the appearance of your teeth? _____		
_____		
_____		
7. If you could change anything about your smile, what would you change? _____		
_____		
_____		

# Medical History

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

*If YES, please explain:*

- Are you under a physician's care now?  No  Yes \_\_\_\_\_
- Have you ever been hospitalized or had a major operation?  No  Yes \_\_\_\_\_
- Have you ever had a serious head or neck injury?  No  Yes \_\_\_\_\_
- Are you taking any medications, pills, or drugs?  No  Yes \_\_\_\_\_
- Do you take, or have you taken Phen-Fen or Redux?  No  Yes \_\_\_\_\_
- Are you on a special diet?  No  Yes \_\_\_\_\_
- Do you take, or have you taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?  No  Yes \_\_\_\_\_
- Do you use tobacco?  No  Yes \_\_\_\_\_
- Do you use controlled substances?  No  Yes \_\_\_\_\_

Women: Are you  Pregnant/Trying to get pregnant?  Nursing?  Taking oral contraceptives?

Are you allergic to any of the following? \_\_\_\_\_

Aspirin  Penicillin  Codeine  Acrylic  Metal  Latex  Local Anesthetics  Other \_\_\_\_\_

- Do you have, or have you had any of the following? \_\_\_\_\_
- |  |  |  |   |   |
|--|--|--|---|---|
| <input type="checkbox"/> AIDS/HIV Positive       | <input type="checkbox"/> Chest Pains               | <input type="checkbox"/> Frequent Headaches    | <input type="checkbox"/> Irregular Heartbeat    | <input type="checkbox"/> Scarlet Fever              |
| <input type="checkbox"/> Alzheimer's Disease     | <input type="checkbox"/> Cold Sores/Fever Blisters | <input type="checkbox"/> Genital Herpes        | <input type="checkbox"/> Kidney Problems        | <input type="checkbox"/> Shingles                   |
| <input type="checkbox"/> Anaphylaxis             | <input type="checkbox"/> Congenital Heart Disorder | <input type="checkbox"/> Glaucoma              | <input type="checkbox"/> Leukemia               | <input type="checkbox"/> Sickle Cell Disease        |
| <input type="checkbox"/> Anemia                  | <input type="checkbox"/> Convulsions               | <input type="checkbox"/> Hay Fever             | <input type="checkbox"/> Liver Disease          | <input type="checkbox"/> Sinus Trouble              |
| <input type="checkbox"/> Angina                  | <input type="checkbox"/> Cortisone Medicine        | <input type="checkbox"/> Heart Attack/Failure  | <input type="checkbox"/> Low Blood Pressure     | <input type="checkbox"/> Spina Bifida               |
| <input type="checkbox"/> Arthritis/Gout          | <input type="checkbox"/> Diabetes                  | <input type="checkbox"/> Heart Mummur*         | <input type="checkbox"/> Lung Disease           | <input type="checkbox"/> Stomach/Intestinal Disease |
| <input type="checkbox"/> Artificial Heart Valve* | <input type="checkbox"/> Drug Addiction            | <input type="checkbox"/> Heart Pace Maker*     | <input type="checkbox"/> Mitral Valve Prolapse* | <input type="checkbox"/> Stroke                     |
| <input type="checkbox"/> Artificial Joint*       | <input type="checkbox"/> Easily Winded             | <input type="checkbox"/> Heart Trouble/Disease | <input type="checkbox"/> Pain in Jaw Joints     | <input type="checkbox"/> Swelling of Limbs          |
| <input type="checkbox"/> Asthma                  | <input type="checkbox"/> Emphysema                 | <input type="checkbox"/> Hemophilia            | <input type="checkbox"/> Parathyroid Disease    | <input type="checkbox"/> Thyroid Disease            |
| <input type="checkbox"/> Blood Disease           | <input type="checkbox"/> Epilepsy or Seizures      | <input type="checkbox"/> Hepatitis A           | <input type="checkbox"/> Psychiatric Care       | <input type="checkbox"/> Tonsillitis                |
| <input type="checkbox"/> Blood Transfusion       | <input type="checkbox"/> Excessive Bleeding        | <input type="checkbox"/> Hepatitis B or C      | <input type="checkbox"/> Radiation Treatments   | <input type="checkbox"/> Tuberculosis               |
| <input type="checkbox"/> Breathing Problem       | <input type="checkbox"/> Excessive Thirst          | <input type="checkbox"/> Herpes                | <input type="checkbox"/> Recent Weight Loss     | <input type="checkbox"/> Tumors or Growths          |
| <input type="checkbox"/> Bruise Easily           | <input type="checkbox"/> Fainting Spells/Dizziness | <input type="checkbox"/> High Blood Pressure   | <input type="checkbox"/> Renal Dialysis         | <input type="checkbox"/> Ulcers                     |
| <input type="checkbox"/> Cancer                  | <input type="checkbox"/> Frequent Cough            | <input type="checkbox"/> Hives or Rash         | <input type="checkbox"/> Rheumatic Fever*       | <input type="checkbox"/> Venereal Disease           |
| <input type="checkbox"/> Chemotherapy            | <input type="checkbox"/> Frequent Diarrhea         | <input type="checkbox"/> Hypoglycemia          | <input type="checkbox"/> Rheumatism             | <input type="checkbox"/> Yellow Jaundice            |

Have you ever had any serious illness not listed above?  Yes  No  N/A \_\_\_\_\_

Comments: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

\*Condition may require medication

## 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 any 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 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 carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X \_\_\_\_\_  
 Signature of patient (or parent if minor)

Apple Dental

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**ACKNOWLEDGEMENT OF RECEIPT OF  
NOTICE OF PRIVACY PRACTICES**

\*You May Refuse to Sign This Acknowledge\*

I, \_\_\_\_\_, have received a copy of  
this office's Notice of Privacy Practices.

\_\_\_\_\_  
Please Print Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
**For Office Use Only**  
\_\_\_\_\_

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because.

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify below)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



1. Copy of Photo ID is requested upon arrival.
2. Payment is due in full at the time of visit for patients without insurance.
3. Payment of Deductible and/or Co-Insurance is due at the time of the visit for patients with insurance.
4. We accept cash, checks, debit cards, credit cards – Mastercard, Visa, Discover, and American Express with ID
5. We do NOT bill out, therefore the person bringing the patient is responsible for payment of the patient's visit.
6. Any balance not paid by the insurance company is your responsibility.
7. You agree to pay any and all attorney fees and collections costs incurred if account is turned over for non-payment.
8. You agree to pay monthly interest in the amount of 1.5% of any unpaid balance.
9. Our office only uses state-of-the-art tooth colored resin fillings. Some insurance consider this cosmetic and downgrade it to the silver amalgam fillings. You are responsible for any difference that your insurance does not cover.

I, \_\_\_\_\_, understand and agree to the  
Please Print  
above payment policy.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_