APPLE DENTISTRY, P.C.

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Welcome To Our Office! Today's Date:

PATIENT INFORMATION

Patient's Last Name	First	Middle	☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms.	Marital Status ☐ Single ☐ Mar ☐ Div ☐ Sep ☐ Wid

Home Phone No.	Cell Phone No.	Best Time for Appointments ☐ AM ☐ Day ☐ Eve ☐ W/End	Birth Date	Age	Sex ☐ M ☐ F

Street Address	City	State	ZIP Code	Social Security #	E-mail Address

City	State	ZIP Code

Occupation	Employer	Employer Phone No.

Referred by (Check one box) ☐ Patient _____ ☐ Dr. _____ ☐ Insurance Plan ☐ Internet
☐ Family ☐ Friend ☐ Advertisement ☐ Other _____

INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)

Person Responsible for Bill	Birth Date	Address (if different)	Home Phone No. (if different)
Is this person a patient here?	☐ Yes ☐ No		

Occupation	Employer	Employer Address	Employer Phone No.

Is this patient covered by insurance? ☐ Yes ☐ No

Subscriber's Name	Subscriber's S.S. #	Birth Date	Group #	Policy #

Patient's Relationship to Subscriber ☐ Self ☐ Spouse ☐ Child ☐ Other _____

IN CASE OF EMERGENCY

Name	Relationship to Patient	Home Phone No.	Work Phone No.

Consent for Services: *The above information is true to the best of my knowledge. I understand that I am responsible for all costs of dental treatment. I authorize my insurance benefits to be paid directly to Apple Dentistry PC. I understand that I am responsible for any balance. I authorize Apple Dentistry PC to release any information required to process my claims or for any other permitted disclosure. I accept the terms of the Notice of Privacy Practices as posted. I authorize the dentist to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care.*

X _____

PATIENT / GUARDIAN SIGNATURE DATE

MEDICAL AND DENTAL HISTORY – have you had any of the following:

☐ Yes ☐ No	Allergies to medications, specify
☐ Yes ☐ No	Allergies to ☐ Penicillin, ☐ Codeine, ☐ Aspirin
☐ Yes ☐ No	Allergies to Latex
☐ Yes ☐ No	Any other Allergies, specify
☐ Yes ☐ No	Heart Murmur
☐ Yes ☐ No	Mitral Valve Prolapse
☐ Yes ☐ No	Rheumatic Fever
☐ Yes ☐ No	High Blood Pressure
☐ Yes ☐ No	Heart Disease or Heart Surgery, specify
☐ Yes ☐ No	Do you require antibiotics before dental treatment?
☐ Yes ☐ No	Do you bleed or bruise easily?
☐ Yes ☐ No	For women: Are you pregnant or may be pregnant?
☐ Yes ☐ No	Do you have now or had a history of Hepatitis? Jaundice?
☐ Yes ☐ No	Tuberculosis
☐ Yes ☐ No	HIV or AIDS
☐ Yes ☐ No	Venereal Disease? Specify:
☐ Yes ☐ No	Kidney Disease? Specify:
☐ Yes ☐ No	Liver disease
☐ Yes ☐ No	Stroke
☐ Yes ☐ No	Radiation treatment
☐ Yes ☐ No	Respiratory problems
☐ Yes ☐ No	Epilepsy
☐ Yes ☐ No	Mental problems
☐ Yes ☐ No	Are you presently under a care of a physician?
	Provide name and phone #
	List your current medications:
☐ Yes ☐ No	Any other medical problems? Specify:
☐ Yes ☐ No	Do you grind your teeth?
☐ Yes ☐ No	Do your gums bleed?
☐ Yes ☐ No	Do you like your smile?

PATIENT / GUARDIAN SIGNATURE _____