We are pleased to welcome you to Applewood Dental. Please take a few minutes to fill out this form as completely as you can, realizing that true and accurate answers are important to the delivery of quality care. All information you provide will be kept confidential. If you have any questions we'll be glad to help you.

PERSONAL

Name____
Last First MI (Preferred)

Birthdate______________ SS#__________________ Gender: [ ] M [ ] F Married: [ ] Y [ ] N

Home Phone________________ Wireless Phone__________________ Work Phone __________________

Email____

Preferred contact method [ ] HmPhone [ ] CellPhone [ ] Work Phone [ ] Email
Preferred contact method for confirmations [ ] HmPhone [ ] CellPhone [ ] Work Phone [ ] Email
Preferred contact method for recall [ ] HmPhone [ ] CellPhone [ ] Work Phone [ ] Email [ ] Mail
Student status if dependent over 19 (for ins) [ ] Non-student [ ] Full time [ ] Part- time
How did you hear about us?

____

(If someone referred you here, please write down their name so we can thank them.)

ADDRESS

Check box if same for entire family [ ]
Address____
Address 2____
City__________________________ State____________________Zip______________________

INSURANCE POLICY 1

Patient's relationship to subscriber: [ ] Self [ ] Spouse [ ] Child
Subscriber Name__________________________________Subscriber ID # ____________________
Insurance Company ____________________________________Phone__________________________

Employer________________________Group Name____________________Group #______________

Please present insurance card to front desk.

INSURANCE POLICY 2

Your relationship to subscriber: [ ] Self [ ] Spouse [ ] Child

Subscriber Name__________________________________ Subscriber ID # ____________________

Insurance Company ____________________________________Phone__________________________

Employer________________________ Group Name____________________Group #______________

FINANCIAL AGREEMENT

* For my convenience, this office may release my information to my insurance company, and receive payment directly from them.
* I understand that if I begin major treatment that involves lab work, I will be responsible for the fee at that time.
* If sent to collections, I agree to pay all related fees and court costs.
* Every effort will be made to help me with my insurance, but if they do not pay as expected, I will still be responsible.
* I agree to pay finance charges of 1.5% per month (18% APR) on any balance 90 days past due.
* I will pay a fee for appointments broken without 24 hours notice.
* Treatment plans may change, and I will be responsible for the work actually done.

Signature____ Date________________

NOTICE OF PRIVACY POLICIES

I have had full opportunity to read and consider the contents of the Notice of Privacy Practices. I understand that I am giving my permission to your use and disclosure of my protected health information in order to carry out treatment, payment activities and healthcare operations. I also understand that I have the right to revoke permission.

Signature____ Date________________

MEDICAL HISTORY

Name: ______________________________ DOB: ________________

Name of Medical Doctor:______________ City/State____________ Date of last Appt:________

Emergency Contact______________ Phone____________Relationship______________

Are you in good health? [ ] Yes [ ] No Any change in your health in the past year? [ ] Yes [ ] No

Any serious operations or hospitalizations? ________________________________

List all the medications or drugs you are now taking:

[ ] None__________________________

List all the medications or drugs you are allergic to:

[ ] None__________________________

List any medical conditions you may have including: [ ] Asthma [ ] Arthritis [ ] Bleeding problems

[ ] Cancer [ ] Diabetes [ ] Heart murmur [ ] Heart trouble [ ] High blood pressure

[ ] Joint replacement [ ] Kidney disease [ ] Liver disease [ ] Lung disease [ ] Mouth sores

[ ] Neurological disorders [ ] Pregnancy [ ] Psychiatric treatment [ ] Radiation [ ] Sinus trouble

[ ] Stroke [ ] Ulcers [ ] History of rheumatic fever [ ] Bisphosphonate use [ ] None

Tobacco use? If so, what kind and how much?______________________________

Unusual reaction to dental injections?______________________________

Reason for today's visit______________________ Are you in pain? ____________

New patients:

Do you have a Panoramic x-ray or Full Mouth x-rays that are less than 5 years old? ____________

Do you have BiteWing x-rays that are less than 1 year old?______________________

Name of former dentist____________________ City/State______________

Date of last cleaning and exam______________

Signature____Date______________

Any additional information: