APPLE DENTAL GROUP P.C.

PATIENT REGISTRATION & HEALTH HISTORY

Account No. _____ Date _____

Patient's Name _____ Birthdate _____ Sex ☐ M ☐ F
"Nickname"

Patient's Address _____ Phone _____
Street City State Zip

Soc. Sec. No. _____ Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

If Employed, By Whom _____ Business Phone _____

Business Address _____

If Student, Name of School _____ Address _____

Nearest Neighbor or Relative's Name, Address, and Phone No. _____

Who To Call In Case of Emergency _____ Phone _____

Referred By _____

PERSON RESPONSIBLE FOR THIS ACCOUNT

Responsible Party's Name _____ Birthdate _____ Sex ☐ M ☐ F

Driver License Number _____ Soc. Sec. No. _____

Street Address (If Diff. Than Above) _____ Phone _____
Street City State Zip

Responsible Party's Employer _____ Years Employed _____

Business Address _____ Phone _____

FOR PATIENT'S COVERED BY INSURANCE

Subscriber's Name _____ Birthdate _____ Soc. Sec. No. _____

Subscriber's Employer _____ Bus. Phone _____

Business Address _____

Insurance Company _____ Group No. _____

Insurance Company Address _____

Insurance Company Phone _____

Patient's Relationship to Subscriber ☐ Self ☐ Spouse ☐ Dependent

Are you familiar with your dental insurance? ☐ Yes ☐ No

Are you covered under more than one Dental Plan? ☐ Yes ☐ No

Secondary Insurance

Subscriber's Name _____ Birthdate _____ Soc. Sec. No. _____

Subscriber's Employer _____ Bus. Phone _____

Business Address _____

Insurance Company _____ Group No. _____

Insurance Company Address _____

Insurance Company Phone _____

Relationship to Patient ☐ Self ☐ Spouse ☐ Dependent

MEDICAL HISTORY

Family Physician _____ Phone _____ Date of Last Physical _____

Height _____ Weight _____

Yes	No	
☐	☐	Have you ever been hospitalized? Reason for hospitalization/medical treatment _____
☐	☐	Are you currently being treated by a physician? Reason: _____
☐	☐	Are you currently taking any drugs or medication (including birth control pills)? Name drugs and reasons for use: _____
		Do you have any allergies or sensitivities?
☐	☐	Aspirin
☐	☐	Codeine
☐	☐	Erythromycin
☐	☐	Penicillin
☐	☐	Others
		Do you have or have you ever had:
☐	☐	Arthritis
☐	☐	Artificial Joint Replacement
☐	☐	Asthma, Emphysema, Lung, Breathing Problems, Shortness of Breath
☐	☐	High Blood Pressure
☐	☐	Blood Diseases, Anemia, Hemophilia, Bruise Easily
☐	☐	Diabetes, Slow Wound Healing
☐	☐	Ear Infections, Hearing Aid
☐	☐	Epilepsy, Fainting Spells, Seizures
☐	☐	Heart Attack, Disease, Pains, or Surgery
☐	☐	Heart Murmur, Rheumatic Fever, Valve Surgery, Pacemaker, Mitral Valve Prolapse
☐	☐	Are you currently in good health?
		Infectious Diseases
☐	☐	Aids (Are you in a possible risk category?)
☐	☐	HIV Positive
☐	☐	Drug use involving needles
☐	☐	Hepatitis A (infectious)
☐	☐	Hepatitis B (serum)
☐	☐	Hepatitis C
☐	☐	Herpes I or II
☐	☐	Tuberculosis
☐	☐	Venereal Disease (Syphilis, Gonorrhea)
☐	☐	Are you pregnant?
☐	☐	Psychiatric care or medications, Nerve Medication
☐	☐	Steroid drugs or therapy
☐	☐	Stomach problems, Bulemia, Ulcers
☐	☐	Thyroid condition
☐	☐	Tumors or Growths
☐	☐	Radiation or Chemotherapy
☐	☐	Is there any other health problem(s) we should be aware of?

Responsibility and Consent Statement

I hereby authorize and request the performance of dental services for myself or for _____
I also give my consent to any advisable and necessary dental procedures, medications, or anesthetics to be administered by attending dentist or by his supervised staff for diagnostic purposes or dental treatment. These records bay include study models, photographs x-rays, and blood studies.

I Understand and acknowledge that I am financially responsible for the services provided for myself or the above named, regardless of insurance coverage.

Treatment plans involving extended credit circumstances may have a credit check done on my credit rating. I also understand that the treatment estimate presented to me is only an estimate. Occasionally, the need may arise to modify treatment. In such a case, I will be informed of the need for additional treatment, and it's fee.

Responsible Party: _____ **Date:** _____
Signature of Dentist: _____ **Date:** _____

Notes & Medical history updates: _____