

# Apollonia Dental Center

## PATIENT INFORMATION

DATE \_\_\_\_\_

NAME \_\_\_\_\_  
LAST FIRST MI  Married  Single  Minor  Male  FemaleADDRESS \_\_\_\_\_  
STREET APT. # CITY STATE ZIP DATE OF BIRTH \_\_\_\_/\_\_\_\_/\_\_\_\_  
MONTH DAY YEARTELEPHONE HOME: ( ) \_\_\_\_\_ WORK: ( ) \_\_\_\_\_ E-MAIL \_\_\_\_\_ @ \_\_\_\_\_  
HOME # WORK #

PLACE OF EMPLOYMENT \_\_\_\_\_ SOCIAL SECURITY # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

DENTAL INSURANCE CO. \_\_\_\_\_ GROUP # \_\_\_\_\_

IF FULL TIME STUDENT, NAME OF SCHOOL \_\_\_\_\_ GRADE LEVEL \_\_\_\_\_

Has any member of your family been treated in our practice?  YES  NO NAME \_\_\_\_\_

Whom may we thank for referring you to our dental practice? \_\_\_\_\_

## FAMILY INFORMATION

### HUSBAND (OR FATHER OF CHILD PATIENT)

LAST FIRST M/I

STREET CITY STATE ZIP

HOME TELEPHONE # WORK TELEPHONE #

BIRTH DATE (MO/DAY/YEAR) SS#

EMPLOYER

DENTAL INSURANCE CO. GROUP #

### WIFE (OR MOTHER OF CHILD PATIENT)

LAST FIRST M/I

STREET CITY STATE ZIP

HOME TELEPHONE # WORK TELEPHONE #

BIRTH DATE (MO/DAY/YEAR) SS#

EMPLOYER

DENTAL INSURANCE CO. GROUP #

## ACKNOWLEDGMENT AND AUTHORITY

- > The information on this page and the dental/medical histories are correct to the best of my knowledge.
- > I hereby authorize the Dentist to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care.
- > I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me.
- > I grant the right to the dentist to release my dental/ medical and other information about my dental treatment to third party payors and/or other health professionals, as appropriate under the circumstances.
- > I also acknowledge full responsibility for the payment of fees for such services and agree to pay for them, in full, AT THE TIME OF SERVICE, unless other arrangements are made in writing with a practice representative.
- > I have received a copy of the Dental Materials Fact Sheet as required by law.
- > I have received a copy of the HIPAA Privacy Policy as required by law.
- > I grant the dental office permission to use the email address given above to contact me with respect to my dental care.

X \_\_\_\_\_  
 Adult Patient  Father or Husband  Mother or Wife  Guardian

Date \_\_\_\_\_ State Driver's License # \_\_\_\_\_

## PERSON TO CONTACT IN CASE OF EMERGENCY

Outside of Immediate Family / Household

Name \_\_\_\_\_

Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Telephone # (\_\_\_\_) \_\_\_\_\_

## PERSON RESPONSIBLE FOR ACCOUNT

Please check one

 Patient  Husband (or Father) Guardian  Wife (or Mother)Responsible party has an account with this office:  Yes  No

## METHOD OF PAYMENT (unless otherwise arranged)

 I will pay in full at each appointment (cash or check) I will pay in full at each appointment  VISA  MC  
Card # \_\_\_\_\_ Exp. Date \_\_\_\_\_ I have a dental benefit plan that I expect will pay for most routine charges. I will pay my deductible and any patient portion at time of service.

# Apollonia Dental Center

## PATIENT HEALTH INFORMATION

DATE \_\_\_\_\_

NAME \_\_\_\_\_

LAST

FIRST

MI

If this is your first dental visit in our office, primary reason:

 COE (comprehensive exam) POE (6 month check-up) PFE (emergency) Other \_\_\_\_\_

## ORAL HEALTH INFORMATION

- Any known dental problems at this time?  Yes  No Describe \_\_\_\_\_
- Are any of your teeth sensitive to hot, cold, biting pressure, or sweets?  Yes  No Describe \_\_\_\_\_
- Do your gums bleed when your brush or floss?  Yes  No Describe \_\_\_\_\_
- Have you ever been told you have periodontal (gum) disease?  Yes  No Describe \_\_\_\_\_
- Are there areas in your mouth you avoid chewing on?  Yes  No Describe \_\_\_\_\_
- Have you had complete set of cavity finding x-rays in the past year?  Yes  No Describe \_\_\_\_\_
- Do your jaw joints (TMJ) click, pop, or cause pain?  Yes  No Describe \_\_\_\_\_
- Are you aware of any nighttime clenching or grinding of your teeth?  Yes  No Describe \_\_\_\_\_
- Have you had your wisdom teeth removed?  Yes  No How long ago? \_\_\_\_\_
- Are you missing any other teeth?  Yes  No For how long? \_\_\_\_\_
- Do your teeth show signs of chipping and wear?  Yes  No Describe \_\_\_\_\_
- Do you have a replacement for missing teeth?  Cemented Bridge  Removable Partial  Full Denture  Implant

## MEDICAL HEALTH INFORMATION

- Physician's Name \_\_\_\_\_ Date last seen \_\_\_\_\_
- Are you under a physician's care now?  Yes  No Discuss reason \_\_\_\_\_
- Any hospitalization in the past 5 years?  Yes  No
- Have you had any serious illnesses or operations?  Yes  No
- Are you taking any medications, pills or drugs?  Yes  No Please List \_\_\_\_\_
- Are you allergic to any medication or substances?  Aspirin  Penicillin  Codeine  Novocain  Metals  Other \_\_\_\_\_
- WOMEN (Please check if applicable)  Pregnant (Due date \_\_\_\_\_)  Nursing
- Do you have, or have you ever had, any of the following? (please check and describe below):

Yes	No	Yes	No	Yes	No
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic fever		Excessive bleeding		Fainting or dizziness	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Any heart problem?		Hepatitis		Stroke	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Antibiotic dental pre-medication		Exposure to AIDS virus		Diabetes	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure		Tuberculosis		Psychiatric treatment	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Malignancy		Other transmittable disease		Epilepsy or seizures	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- Do you know of any reason why routine dental procedures might pose a risk to you, the dental staff, or other patients?  Yes  No
- Is there anything important about your medical condition we have not asked? \_\_\_\_\_

Remarks \_\_\_\_\_

To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status or if my medications change, I shall inform the dentist and staff at the next appointment without fail.

X \_\_\_\_\_ Date \_\_\_\_\_  
Patient's Signature (Parent or Guardian)

## MEDICAL INFORMATION UPDATES

Reviewed by \_\_\_\_\_ Date \_\_\_\_\_

I have read my MEDICAL HISTORY dated \_\_\_\_\_ and confirm that it adequately states past and present conditions.

DATE	EXCEPTIONS	PATIENT'S SIGNATURE	REVIEWED BY
_____	NONE <input type="checkbox"/>	_____	_____
_____	NONE <input type="checkbox"/>	_____	_____
_____	NONE <input type="checkbox"/>	_____	_____