Welcome To Appleseed Dental

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Thank you for choosing Appleseed Dental for your dental needs. Please complete this form in ink and answer everything to the best of your knowledge. Once completed, please sign and date. If you have any questions or concerns, do not hesitate to ask for assistance, we will be happy to help.

TODAY'S DATE: _____

PATIENT INFORMATION:

Name: _____ DOB: _____ Sex: M F
First MI Last

Pt. Social. Sec. #: ___-___-___ Are you: Minor -- Married -- Divorced -- Widowed -- Single -- Separated (Circle one)

Address: _____ City: _____ State: ____ Zip: _____
Home #: _____ Work #: _____ Cell #: _____ Email: _____
Which number do you prefer we call? (Circle one) H W C May we leave messages: With another person? Yes No
On your answering machine? Yes No

Your Employer (Parent's if minor): _____ Occupation: _____
Employer's Address: _____ City: _____ State: _____ Zip: _____
Are you a college student? Yes No If yes, Where? _____ City/State: _____
Spouse/ Parent's Name: _____ Workplace: _____ Work #: _____
Person to contact incase of emergency: _____ Phone #: _____

RESPONSIBLE PARTY:

Name: _____ DOB: _____ SS#: ___-___-___ Phone #: _____
Address: _____ City: _____ State: ____ Zip: _____
(If different than above)

REFERRAL: Whom may we thank for referring you to our practice? _____

INSURANCE INFORMATION: We will submit your claim to the insurance company provided we have the necessary and complete information. It is your responsibility to let us know of any changes or updates with your insurance status. Ultimately, we will not be responsible for the follow- up of delayed insurance payments or for the negotiation of any settlements of disputed claims. If the claim is delayed more than 30 days, the patient is responsible for the payment in full.

PRIMARY INSURANCE

Name of Insurance: _____
Address (Claims): _____
City: _____ State: _____ Zip: _____
Phone: (___)_____
Subscriber's Name: _____
Subscriber's ID#: _____
SS#: _____ DOB: _____
Home Address if different from pt: _____
City: _____ State: _____ Zip: _____
Employer: _____
Relationship to Patient: _____
Group number: _____

SECONDARY INSURANCE

Name of Insurance: _____
Address (Claims): _____
City: _____ State: _____ Zip: _____
Phone: (___)_____
Subscriber's Name: _____
Subscriber's ID#: _____
SS#: _____ DOB: _____
Home Address if different from pt: _____
City: _____ State: _____ Zip: _____
Employer: _____
Relationship to Patient: _____

I understand and agree that (regardless of my insurance status); I am ultimately responsible for the balance due on my account for all services rendered. I have read all information on this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my insurance status or the above information.

X _____ _____
Signature (Parent if Minor): Date:

Eaglesoft Medical History(Copy)(Copy)

Patient Name: Birth Date: Date Created:

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.

Are you under a physician's care now?	◯ Yes ◯ No	If yes
Have you ever been hospitalized or had a major operation?	◯ Yes ◯ No	If yes
Have you ever had a serious head or neck injury?	◯ Yes ◯ No	If yes
Are you taking any medications, pills, or drugs?	◯ Yes ◯ No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	◯ Yes ◯ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	◯ Yes ◯ No	If yes
Do you use tobacco?	◯ Yes ◯ No	
Do you use controlled substances?	◯ Yes ◯ No	If 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 ☐ Sulfa Drugs ☐ Local Anesthetics

Other? ☐ If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive	◯ Yes ◯ No	Radiation Treatments	◯ Yes ◯ No	Alzheimer's Disease	◯ Yes ◯ No	Diabetes	◯ Yes ◯ No
Hepatitis A,B,C	◯ Yes ◯ No	Recent Weight Loss	◯ Yes ◯ No	Drug Addiction	◯ Yes ◯ No	Anxiety	◯ Yes ◯ No
Anemia	◯ Yes ◯ No	Easily Winded	◯ Yes ◯ No	Rheumatic Fever	◯ Yes ◯ No	Autism	◯ Yes ◯ No
Emphysema	◯ Yes ◯ No	High Blood Pressure	◯ Yes ◯ No	Arthritis/Gout	◯ Yes ◯ No	Epilepsy or Seizures	◯ Yes ◯ No
High Cholesterol	◯ Yes ◯ No	Artificial Heart Valve	◯ Yes ◯ No	Excessive Bleeding	◯ Yes ◯ No	Artificial Joint	◯ Yes ◯ No
ADD/ADHD	◯ Yes ◯ No	Asthma	◯ Yes ◯ No	Fainting Spells/Dizziness	◯ Yes ◯ No	Irregular Heartbeat	◯ Yes ◯ No
Sinus Trouble	◯ Yes ◯ No	Blood Disease	◯ Yes ◯ No	Frequent Cough	◯ Yes ◯ No	Kidney Problems	◯ Yes ◯ No
Asperger's Syndrome	◯ Yes ◯ No	Blood Transfusion	◯ Yes ◯ No	Leukemia	◯ Yes ◯ No	Stomach/Intestinal Disease	◯ Yes ◯ No
Breathing Problems	◯ Yes ◯ No	Frequent Headaches	◯ Yes ◯ No	Liver Disease	◯ Yes ◯ No	Stroke	◯ Yes ◯ No
Low Blood Pressure	◯ Yes ◯ No	Cancer	◯ Yes ◯ No	Lung Disease	◯ Yes ◯ No	Thyroid Disease	◯ Yes ◯ No
Chemotherapy	◯ Yes ◯ No	Mitral Valve Prolapse	◯ Yes ◯ No	Tonsillitis	◯ Yes ◯ No	Chest Pains	◯ Yes ◯ No
Heart Attack/Failure	◯ Yes ◯ No	Osteoporosis	◯ Yes ◯ No	Cold Sores/Fever Blisters	◯ Yes ◯ No	Pain in Jaw Joints	◯ Yes ◯ No
Tumors or Growths	◯ Yes ◯ No	Congenital Heart Disorder	◯ Yes ◯ No	Heart Trouble/Disease	◯ Yes ◯ No	Psychiatric Care	◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian

X Date:_____