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.

TODAY'S DATE: _____

PATIENT INFORMATION

Name: _____ DOB:_____

Social Sec.# _____-_____-_____ Gender: M F

Address: _____ City: _____State: _____ Zip:_____

Home#:_____ Cell#_____ work#_____

Email address: _____

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: _____phone:_____

Person to contact in case of emergency:_____ phone:_____

May we leave messages: With another person? Yes No On an answering machine? Yes No (Circle yes or no)

(if different from above)

New patients: How did you hear about our practice?_____

RESPONSIBLE PARTY/POLICY HOLDER:

Name: _____DOB:_____SS#:_____- _____-_____Phone#:_____

Address:_____City:_____State:_____Zip:_____

INSURANCE INFORMATION: We will submit your claim to the insurance company provided we have the necessary and complete information.

I agree that I am responsible for all services rendered to the patient and that payment is due and payable to the practice at the time services are rendered. I agree to pay all deductibles and co-pays at the time of service (if I have dual insurance coverage, my co-pay or deductible will be based on the primary coverage). I understand that while the practice will file claims with my insurance company on my behalf, I remain responsible to the practice for what is not paid by my insurance company. I also understand that if the Practice cannot verify insurance benefits/eligibility for me prior to treatment that I will pay in full for the services at the time they are rendered. I understand that the Practice may charge: 1)a late fee if payment on my account is not received by the due date; 2)an amount equal to $35.00 but not to exceed the maximum amount permitted by law for each returned check, and 3)a fee for each appointment that is missed/canceled without at least 24 hours advance notice. I agree to the extent permitted by law, that if my account balance is referred to any agency or attorney(s) for collection purposes, to pay reasonable attorney's fees and any expenses or costs relating to the collection proceeding, including court costs. I understand that if treatment or care is suspended at any time by the patient, all fees for professional services rendered will be immediately due and payable. I authorize payment directly to the practice.

X_____

_____

Signature (parent, if minor) **Date**

Patient Medical/ Dental History

Patient's Name:_____**DOB**: _____

In order to have the safest dental experience possible, it is necessary that we have an accurate medical history, including a listing of all medications that you take.

Name of physician: _____Office phone: _____Date of last visit: _____

Name of specialist: _____Office phone: _____Date of last visit: _____

YES	NO	
☐	☐	Have there been any changes in your general health in the past year? _____
☐	☐	Have you had any illness, operation or hospitalization in the past 5 years?_____
☐	☐	Are you under medical treatment right now? _____

Do you have or have had any of the following conditions? Please circle "yes" or "no.

Y N High blood pressure	Y N Acid reflux	Y N Epilepsy
Y N Heart disorders	Y N Tuberculosis (TB)	Y N Cancer
Y N Pacemaker	Y N Sinus trouble	Y N Radiation treatment
Y N Artificial heart valve	Y N Asthma	Y N Chemotherapy
Date of surgery _____	Y N Thyroid disease	Y N Psychiatric treatment
Y N Rheumatic fever	Y N Diabetes	Y N Autism
Y N Blood disorders	Y N Hepatitis	Y N Asperger's syndrome
Y N Artificial joint replacement	Y N Liver disease	Y N ADD/ADHD
Date of surgery_____	Y N HIV/AIDS	Y N Dementia/alzheimer's
Y N Other_____	Y N Arthritis	Y N Anxiety

Please list all medications that you are currently taking. (Prescription and over the counter including aspirin, blood thinners, vitamins, herbal remedies.)

Medication **Reason**

_____

_____

_____

Is an antibiotic required before dental treatment? Y N If yes, specify_____

Do you have any known allergies? Y N If yes, please specify_____

AUTHORIZATION

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including diagnosis and the records of any treatment of examination rendered to my child or me during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the provider. The insurance may pay less than the actual bill for services. I agree to be responsible for any co-payments and deductibles that my insurance does not cover, as well as for any denied services.

X_____ Date_____