We are pleased to welcome you to Apple Grove Dental!
Please take a few minutes to fill out this form as completely as you can.
If you have any questions, we are glad to assist you.

Patient Information **Today's Date: ______________**

Name: ____
Last First Middle Initial Preferred Name

Address: ____
Street City State Zip Code

SSN: ____________________________ Date of Birth___________________ Gender: □ M □ F

Home Phone #: ___________________ Cell #:_____________________ Work #:_____________________

(Please circle your preferred contact number above) Employer:___________________________

Email:____

If patient is under 18 years, please also complete the following guardian information:

Guardian Name: ____
Last First Middle Initial Preferred Name

Date of Birth____________________ Gender: □ M □ F Email:____

Home Phone #: __________________ Cell #:___________________ Work #:______________________

Insurance Policy 1 *Relationship to Patient*: □ Self □ Spouse □ Parent □ Child □ Other___________________

Subscriber name:____
Last First Middle Initial

Subscriber Date of Birth: ______________ Subscriber SSN:_________________ Subscriber ID #: __________________

Insurance Company: ____________________________ Insurance Telephone No.: ________________________

Employer: _________________________Group Name: ___________________________Group #:_________________

Insurance Policy 2 *Relationship to Patient*: □ Self □ Spouse □ Parent □ Child □ Other___________________

Subscriber name:____
Last First Middle Initial

Subscriber Date of Birth: ______________ Subscriber SSN:_________________ Subscriber ID #: __________________

Insurance Company: ____________________________ Insurance Telephone No.: ____________________

Employer: _________________________Group Name: ___________________________Group #:_________________

How did you hear about us? (If someone referred you, please provide their name so we can thank them!)

____

The information below will help us to provide you with the best care.
If you have any questions, we are glad to assist you.

Name:_______________________________________ Date of Birth:_______________ Today's Date:______________

Reason for today's visit: _______________________________________ Are you in pain? □ Yes □ No

Medical History Information

Name of Medical Doctor:____ City/State:________________________

Emergency Contact:___________________________ Phone #:__________________ Relationship:__________________

Please mark any of the following which you have had or have at present:

□ Alcohol/Drug Abuse
□ Anemia
□ Arthritis
□ Asthma/Hay fever
□ Blood thinners
□ Bruise or Bleed Easily
□ Canker or Cold sores
□ Chemo (Cancer, Leukemia)
□ Cortisone Medicine
□ Depression/Anxiety
□ Diabetes
□ Dry Mouth
□ Eating Disorder
□ Emphysema
□ Epilepsy or Seizures
□ Glaucoma
□ Heart attack or Stroke
□ Heart Disease/Angina
□ Heart Murmur
□ Heart Pacemaker
□ Hepatitis
□ High Blood Pressure
□ HIV/AIDS
□ Kidney Trouble
□ Osteoporosis
□ Pain in Jaw Joints
□ Rheumatic Fever
□ Rheumatism
□ Scarlet Fever
□ Sexually Transmitted Disease
□ Sickle Cell Disease
□ Sinus Problems
□ Thyroid Disease
□ Tuberculosis
□ Other:____

Does your medical doctor recommend medication prior to dental treatment? □ Yes □ No

If female, are you pregnant? □ Yes □ No If yes, # of weeks: _________

Tobacco use? □ Yes □ No If yes, what kind and how often? ____

Please list all medications or drugs you are now taking:

____

Please mark any of the following medications you are allergic to:

□ Aspirin
□ Barbiturates, sedatives, or sleeping pills
□ Codeine
□ Other narcotics
□ Epinephrine
□ Iodine
□ Latex Rubber
□ Local Anesthetics
□ Penicillin
□ Other antibiotic
□ Sulfa Drugs
□ Other:______________

I certify that all of the above information is true to the best of my knowledge.

____
Patient Name (printed)

____
Guardian Name (printed), if patient is <18 years

____
Patient/Guardian Signature

I have reviewed all information presented above.

____
Dr.'s Signature