



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:

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

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:

- | | | | |
|---|--|--|---------------------------------------|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Codeine | <input type="checkbox"/> Latex Rubber | <input type="checkbox"/> Sulfa Drugs |
| <input type="checkbox"/> Barbiturates, sedatives, or sleeping pills | <input type="checkbox"/> Other narcotics | <input type="checkbox"/> Local Anesthetics | <input type="checkbox"/> Other: _____ |
| | <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Penicillin | |
| | <input type="checkbox"/> Iodine | <input type="checkbox"/> Other antibiotic | |

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

I have reviewed all information presented above.

Patient Name (printed)

Dr. Chung's Signature

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

Patient/Guardian Signature