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

Are you happy with your smile? □ Yes □ No
What concerns do you have today? _____

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)

I have reviewed all information presented above.

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

_____
Dentist Signature

_____
Patient/Guardian Signature