



# APPLE DENTAL HEALTH SERVICES, P.C.

113-16 76th Rd. Forest Hills, NY 11376  
Toll Free 1-888-83-APPLE (27753)

## Personal Information

Name

Address

City

State

ZIP

Phone

Work Phone

Employer

DOB

Ins.Co.

Spouse Ins.

SS#

Spouse SS#

Spouse Employer

Spouse Name

Spouse DOB

Date of last full mouth x-rays

In case of emergency call

Another Phone # to reach you

Physician phone number

Cellphone number

## Confidential Dental Health Information

Do You Have A History Of:		
YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	RHEUMATIC FEVER
<input type="checkbox"/>	<input type="checkbox"/>	HEART MURMUR
<input type="checkbox"/>	<input type="checkbox"/>	HEART TROUBLE
<input type="checkbox"/>	<input type="checkbox"/>	PACE MAKER/HEART SURGERY
<input type="checkbox"/>	<input type="checkbox"/>	HIGH BLOOD PRESSURE
<input type="checkbox"/>	<input type="checkbox"/>	LOW BLOOD PRESSURE
<input type="checkbox"/>	<input type="checkbox"/>	BLOOD DISEASE
<input type="checkbox"/>	<input type="checkbox"/>	H.I.V. POSITIVE
<input type="checkbox"/>	<input type="checkbox"/>	DIABETES
<input type="checkbox"/>	<input type="checkbox"/>	EXCESSIVE BLEEDING
<input type="checkbox"/>	<input type="checkbox"/>	BRUISE EASILY
<input type="checkbox"/>	<input type="checkbox"/>	ANEMIA
<input type="checkbox"/>	<input type="checkbox"/>	KIDNEY DISEASE
<input type="checkbox"/>	<input type="checkbox"/>	HEPATITIS
<input type="checkbox"/>	<input type="checkbox"/>	ULCERS OR STOMACH PROBLEMS
<input type="checkbox"/>	<input type="checkbox"/>	LIVER DISEASE
<input type="checkbox"/>	<input type="checkbox"/>	LUNG DISEASE
<input type="checkbox"/>	<input type="checkbox"/>	BREATHING PROBLEMS
<input type="checkbox"/>	<input type="checkbox"/>	TUBERCULOSIS
<input type="checkbox"/>	<input type="checkbox"/>	ASTHMA
<input type="checkbox"/>	<input type="checkbox"/>	EPILEPSY
<input type="checkbox"/>	<input type="checkbox"/>	ALLERGIES TO DRUGS
<input type="checkbox"/>	<input type="checkbox"/>	FAINTING OR DIZZINESS
<input type="checkbox"/>	<input type="checkbox"/>	DO YOU TAKE MEDICATIONS
<input type="checkbox"/>	<input type="checkbox"/>	FEAR OF DENTIST?
<input type="checkbox"/>	<input type="checkbox"/>	HAVE YOU HAD ANY SURGERIES
<input type="checkbox"/>	<input type="checkbox"/>	VENEREAL DISEASE
<input type="checkbox"/>	<input type="checkbox"/>	ARTHRITIS
<input type="checkbox"/>	<input type="checkbox"/>	OTHER ILLNESSES
<input type="checkbox"/>	<input type="checkbox"/>	PRESENTLY UNDER DOCTORS CARE
<input type="checkbox"/>	<input type="checkbox"/>	PAIN IN JAW OR EARS
<input type="checkbox"/>	<input type="checkbox"/>	ANY OTHER(S) <input type="text"/>

### List Medications:

1.
2.
3.
4.
5.

### Medications allergic to:

1.
2.
3.
4.
5.

### Treatment Plan Release / Sign Patient or Guardian

Date

Signature

### Authorization of payment of benefits / I authorize insurance payment to APPLE DENTAL

Date

Signature

### I agree to the Terms of Payment contracted between me the patient and Apple Dental Health Services, P.C.

Date

Signature