



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



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Dental History

Patient's Number

Date

Patient's Name

First Name Last Name Initial Date of Birth

1. What is the purpose of this visit?

- Cleaning
- Regular Checkup
- Tooth Pain
- Dental Injury/Emergency
- Other

2. When was your last dental visit? (MM/YY)

3. What was done during that visit?

- Cleaning
- Checkup
- Extraction/Tooth Replacement
- Root canal treatment
- Other

4. When was your Cleaning? Months Ago

5. How often do you visit the dentist? Once every Months Ago

Have you ever have:

YES NO

- Periodontal treatment (gum disease)?
- Endodontic treatment (root canal)?
- Orthodontic treatment (braces)?
- Jaw surgery?
- Dental implants?
- Teeth lost or removed? If yes, why?

- Looseness
- Infection/Nerve Damage
- Wisdom Teeth
- Other:

Do you have:

YES NO

- Lumps or sores in your mouth
- Pain around ear or neck
- Frequent Headaches
- Frequent blisters on lips or mouth
- Clenching or grinding teeth
- Difficulty swallowing
- Breathing through your mouth
- Jaw clicking or popping
- Gum bleeding and pain
- Loose, tipped, shifted or chipped teeth
- Have tooth sensitivity to the following:

- Heat Cold
- Sweet Pressure

... continuation

YES NO

- Do you feel unhappy about the appearance of your teeth? If yes, why are you unhappy about?
 - Not white enough
 - Not strong enough
 - Other
- Do you feel your breath is offensive at times?
- Do you smoke?
 - If yes packs per day
- Do you drink alcohol?
- Do you use IV drugs?
- Do you drink soda, coffee with sugar or any other product with sugar content?
 - If yes, cups / cans per day

DO YOU USE ANY OF THE FOLLOWING?

- Dental floss If yes times per day
- Fluoridated water week
- Fluoride toothpaste month
- Fluoride rinse or gel
- Mouth-rinses
- Tartar-control toothpaste

Is there anything else you would like to tell us about your oral health?

How did you hear about us?

- Verizon Yellow Pages Queens Chronicle
- Ambassador Yellow Radio AM
- Pages Insurance
- New York Post Walk By
- New York Daily News Other
- Senior News Friend
- Queens Ledger If Friend, Who?

I certify that the above information is complete and accurate to the best of my knowledge I understand that it is my responsibility to inform this office of any change in my oral health status.

Patient / Guardian Signature _____

Date: _____

Dentist Signature _____

Date: _____



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Dental Health Consent Form

Patient's Name

First Name Last Name Initial Date of Birth

I hereby authorize Dr. and others whom he/she may designate as his/her associates or assistants (collectively "dental team") to perform upon me the following operations and/or procedures:

- | | |
|--|--|
| <input type="checkbox"/> Tooth Filling | <input type="checkbox"/> Crown, Bridges, and Caps |
| <input type="checkbox"/> Tooth Extraction | <input type="checkbox"/> Dentures (Complete or Partial) |
| <input type="checkbox"/> Periodontal Treatment | <input type="checkbox"/> Endodontic Treatment (Root Canal) |

Other

I understand that during the course of the planned operations and/or procedures unanticipated conditions may arise and necessitate procedures in addition to or different from those planned. I authorize the dental team to perform upon me additional and/or different procedures that they may consider necessary.

I consent to the administration of anesthesia, antibiotics and other medications that may be deemed necessary for my treatment. I understand that such medications can cause adverse reactions that include pain, swelling of tissues, dizziness, cardiac arrest, and vomiting.

I will be advised of the purpose and nature of the above treatment, expected results, and material complications and risks that may arise. I will be informed of possible alternatives, including the option of non-treatment, and the consequences of each. I will be given sufficient opportunity to ask questions, and all of my questions will be answered to my satisfaction.

I understand that any surgical procedure can entail certain complications. I recognize that common to oral surgery is the potentials for pain, swelling, bruising, bleeding and allergic reactions. I also realize that other complications can include damage to adjacent teeth or dental restorations, opening of the sinus, infection, jaw fracture, nerve injury, and small root fragments remaining in the jaw that may require addition operations to extract.

I have provided information concerning my physical and mental health as accurately and completely as possible. I agree to cooperate fully with the dental team while I am under their care. I acknowledge that no guarantee have been made to me concerning the results of the operation or procedure. I confirm that I have read and fully understood the content of this form prior to my signing.

Patient or Guardian Signature _____ Date _____

Dentist Signature _____ Date _____

Witness Signature _____ Date _____



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Patient's Name

First Name

Last Name

Initial

This is to acknowledge that I have read APPLE DENTAL HEALTH SERVICES, P.C. Notice of Privacy Practices.

Patient Signature

Date

INTERNAL USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign.
 Communication barriers prohibited obtaining the acknowledgement
 Other (please specify)

Signature of Staff

Date

If our office needs to call you with test results, appointment follow-ups, any reminders, etc, please advise us below where to try and reach you and if we can leave you a detailed message if you are not available to talk when we call. (i.e., - on answering machine at home, at work, do not leave a message, or just leave message to call our office, etc.)

Home Phone #

Cell Phone # (if applicable)

Permission to leave message on Answering Machine/Voice Mail YES NO

Permission to leave message with Family Members YES NO

Work Phone # (if applicable)

Permission to call work # YES NO

Other instructions