Apple Street Dental

Patient Information

Name ____
LAST FIRST MIDDLE INITIAL NICKNAME

Address ____
STREET

____
CITY STATE ZIP

Employer ____________________ Military ID ____________________

Birth date Social Security #

May we contact you at work? ❑ Yes ❑ No

Phone: Home ( ) ____________________ Gender: ❑ Male ❑ Female

Work ( ) ____________________ Mobile( ) ____________________

Email address : ____

Emergency Name and Phone number ____

Relationship to the patient ____

How did you hear about us? Please circle one : Mailer Sign/Drive-by Internet/Google Newspaper Radio Insurance Co. Facebook Word of mouth

Other_________

I understand that I am responsible for all costs for dental treatment. I hereby authorize Apple Street Dental to administer such medication and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the medical history is correct to the best of my knowledge.

____ ____________________

SIGNATURE OF PATIENT/GUARDIAN DATE

What was the reason for today's visit? ____

Would you be interested in Nitrous Oxide to make your visit easier today? ____________________

Do you love your smile? ____

When was your last dental cleaning? ____

Why did you leave your last dentist?

Apple Street Dental

What did you like *most* about your last dentist

Apple Street Dental

Other Information

You current health is ( ) Good ( ) Fair ( ) Poor
Are you currently in pain? ( ) Yes ( ) No
How many times do you: Floss per week? Brush per day?
Have you ever had gum treatment? ( ) Yes ( ) No
Are your teeth sensitive to hot, cold or sweets? ( ) Yes ( ) No
Do you take any Body Density medications? ( ) Yes ( ) No

Medical History and Information

Conditions

- ❑ Abnormal Bleeding
- ❑ Alcohol Abuse
- ❑ Allergies
- ❑ Anemia
- ❑ Angina Pectoris
- ❑ Arthritis
- ❑ Artificial Heart Valve
- ❑ Asthma
- ❑ Blood Transfusion
- ❑ Cancer
- ❑ Chemotherapy
- ❑ Colitis
- ❑ Congenital Heart Defect
- ❑ Diabetes
- ❑ Difficulty Breathing
- ❑ Drug Abuse
- ❑ Emphysema
- ❑ Epilepsy
- ❑ Facial Surgery
- ❑ Fainting Spells
- ❑ Fever Blisters
- ❑ Frequent Headaches
- ❑ Glaucoma
- ❑ HIV+ Aids
- ❑ Heart Attack
- ❑ Heart Murmur
- ❑ Heart Surgery
- ❑ Hemophilia
- ❑ Hepatitis A
- ❑ Hepatitis B
- ❑ Hepatitis C
- ❑ High Blood Pressure
- ❑ Joint Replacement
- ❑ Kidney Problems
- ❑ Liver Disease
- ❑ Low Blood Pressure
- ❑ Mitral Valve Prolapse
- ❑ Pace Maker
- ❑ Psychiatric Problems
- ❑ Radiation Therapy
- ❑ Rheumatic Fever
- ❑ Seizures
- ❑ Sexually Transmitted Disease
- ❑ Shingles
- ❑ Sickle Cell Disease
- ❑ Sinus Problems
- ❑ Stroke
- ❑ Thyroid Problems
- ❑ Tuberculosis
- ❑ Ulcers

Allergies

- ❑ Aspirin
- ❑ Codeine
- ❑ Dental Anesthetics
- ❑ Erythromycin
- ❑ Latex
- ❑ Metals
- ❑ Penicillin
- ❑ Sulfa
- ❑ Tetracycline

Other

Do you Smoke? ( ) Yes ( ) No
Do you use Tobacco? ( ) Yes ( ) No
Do you usually Pre-Med before your dental visits? ( ) Yes ( ) No

If Female:
Are you Pregnant? ( ) Yes ( ) No
Are you Nursing? ( ) Yes ( ) No

Do you suffer from any other conditions/disorders that are not listed above.

Please list any medications that you are currently taking:

I attest that the information given is true and accurate to the best of my knowledge

PATIENTS SIGNATURE DATE

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PARENT/GUARDIAN SIGNATURE DATE