



Apple Dental Group

113-16 76th Road Forest Hills, NY 11375

Patient Information

Print Name: _____ Date: _____
Last First Middle Initial

Address: _____
Street City State Zip Code

Date of Birth: ____/____/____ Social Security Number: _____

Phone (Home): _____ (Work): _____ (Cell): _____

Email: _____ Sex: Male Female Unspecified

Emergency Contact: _____ Emergency Contact Phone: _____

What is the Purpose of this Visit?

Comprehensive Exam Cleaning Emergency Dental Injury Other: _____

Medical History

Are you under care of a physician? Yes No

Name of Physician: _____ Phone: _____

Any hospitalizations or surgeries in the last 5 years? Yes No

If yes please explain: _____

Allergies: _____

Medications: _____

Do you smoke Yes No If yes how many per day? _____ Drink alcohol? Yes No Recreational Drugs Yes No

Have your ever had any of the following? Please check those that apply:

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Drug Abuse | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Rheumatism |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Stomach Issues |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Fainting | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Psychiatric Disorders | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Head Injuries | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Tumors |
| <input type="checkbox"/> Bisphosphonates- Boniva, Prolia, Fosamax | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Pregnant (Due Date _____) | <input type="checkbox"/> Thyroid Issues |
| <input type="checkbox"/> Blood Disorder | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Venereal Diseases |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> Other Condition(s): _____ |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Rheumatic Fever | _____ |

Any health problems need clarification? Yes No

If yes, please explain: _____

Name: _____

D.O.B: _____

Preferred Pharmacy

Name: _____ Address _____

Street

City

State

Zip Code

Phone: _____

Dental History

When was your last dental visit? _____ (MM/YY) How often do you visit the dentist? Every _____ months

Last X-Rays: _____ Last dental treatment? Check-Up Cleaning Extraction Root Canal Treatment Other

Do you feel unhappy by the appearance of you teeth? Yes No Do you wear removable dentures? Yes No

Have you ever had?

Periodontal treatment Yes No Lumps or sores in mouth Yes No Bleeding gums Yes No

Endodontic treatment Yes No Pain in ears or neck Yes No Tooth sensitivity Yes No

Orthodontics Yes No Frequent Headaches Yes No Frequent Blisters on lips and mouth Yes No

Jaw surgery Yes No Clenching or grinding Yes No Shifting Teeth Yes No

Dental Implants Yes No Extractions Yes No Jaw Clicking or popping Yes No

How many times a day do you brush? _____ Floss? _____ Rinse with fluoride mouth rinse Yes No

Dental Insurance Information

Primary

Is subscriber the same as patient? Yes No

Subscriber Information: _____

Last

First

Middle Initial

Employer Name: _____ Insurance Company: _____

Subscriber SSN: _____ Policy Number: _____

Group/Contract Number: _____ Date of Birth: _____

Patient Relationship to Subscriber: Child Dependent Husband Self Wife Other

Secondary

Is subscriber the same as patient? Yes No

Subscriber Information: _____

Last

First

Middle Initial

Employer Name: _____ Insurance Company: _____

Subscriber SSN: _____ Policy Number: _____

Group/Contract Number: _____ Date of Birth: _____

Patient Relationship to Subscriber: Child Dependent Husband Self Wife Other

Who may we thank for referring you? Friend Relative TV Radio School Newspaper Dental Office

Other _____ Name of referring office or person: _____

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 the office of any changes to my health and/or oral status.

Signature: _____

Date: _____

Patient/Parent/Guardian

Name: _____

D.O.B: _____

Consent for Services and Financial Policy

Thank you for choosing us as your dental care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. All patients must read and sign this form before seeing the doctor. As a condition of your treatment by our office, financial arrangements must be made in advance. Our practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

WE ACCEPT CASH, CHECKS, VISA, MASTERCARD, AMERICAN EXPRESS, DISCOVER, and CARE CREDIT.

DENTAL INSURANCE: Our office will gladly work with you to help get the maximum benefit available to you. Most dental insurance plans do not cover 100% of your treatment costs. Therefore, you will be expected to pay your deductible and your estimated co-payment on the day the services are rendered. We will gladly file your insurance claim as a courtesy. Many variables exist from carrier to carrier (i.e. deductibles, annual maximums, allowable fee limitations, non-covered procedures and other restrictions): therefore, we cannot guarantee any estimated charges. Your policy and benefits are an agreement between you and the insurance company so ultimately you are responsible for all charges. Please know that we will do everything possible to see that you receive the full benefits from your insurance company. If for some reason your insurance company has not paid their estimated portion within 60 days from the start of treatment, you are responsible for payment in full at that time. Treatment could be altered if your dental needs change. The patient will be notified of any change(s) in treatment. We will gladly file all dental claims for any given treatment but we are not party to any insurance programs or contracts. The balance is YOUR RESPONSIBILITY whether your insurance company pays for your treatment or not. It is your responsibility to inform us of any changes in your insurance coverage.

REGARDING INSURANCE PLANS WHERE WE ARE A PARTICIPATING PROVIDER: All ESTIMATED portions and deductibles are due prior to treatment. In the event your insurance coverage changes to a plan where we are a non-participating provider, refer to above paragraph. You are responsible for advising this office if you have a change in your insurance coverage prior to your appointment.

TREATMENT PLAN ESTIMATES: We prepare TREATMENT PLAN ESTIMATES so that patients can understand their estimated cost of recommended restorative treatment prior to start. This Estimate is a good-faith attempt to predict the cost of your treatment based on the known facts when estimate is made. As your treatment progresses, your dentist may determine in consultation with you that additional or a change in treatment may be necessary and that would change the estimated cost.

I have read the above conditions of treatment and payment and agree to the contents.

Signature: _____

Patient/ Parent/ Guardian

Date: _____

Name: _____

D.O.B: _____

Acknowledgement of Receipt of Notice of Privacy Practices

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by visiting our Website at www.appledental.net

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such revocation shall not affect any disclosures we have already made in reliance on your prior Consent.

The Patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Policies.
- The Patient has the right to restrict the uses of their information.
- The Patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition treatment upon execution of this Consent.

No insurance can be billed on the patient's behalf without this signed HIPAA Consent Form, therefore payment in full is required on the same day of services I, as the above named patient or parent/legal guardian, have had full opportunity to read and consider the contents of this Consent form and the Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment and health care operations.

The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Signature: _____ **Date:** _____

Patient/ Parent/ Guardian