

WELCOME

PATIENT INFORMATION

Date _____
Patient _____
Address _____

Sex: M F Age _____ Birthdate _____
 Single Married Widowed Separated Divorced
Patient SS# _____
Occupation _____
Employer _____
Employer Address _____
Employer Phone _____
Spouse's Name _____
Birthdate _____
Occupation _____
Spouse's Employer _____
Whom may we thank for referring you? _____

DENTAL INSURANCE

Who is responsible for this account? _____
Relationship to Patient _____
Insurance Co. _____
Group # _____
Is patient covered by additional insurance? YES NO
Subscriber's Name _____
Birthdate _____ SS # _____
Relationship to Patient _____
Insurance co. _____
Group # _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature _____
Relationship _____ Date _____

PHONE NUMBERS

Home _____ Work _____ Ext _____ Spouse's Work _____
Best time and place to reach you _____ Cell _____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name _____ Relationship _____
Home Phone _____ Work Phone _____

DENTAL HISTORY

Reason for today's visit _____	Burning sensation on tongue <input type="checkbox"/> Yes <input type="checkbox"/> No	Loose teeth or broken fillings <input type="checkbox"/> Yes <input type="checkbox"/> No
Former Dentist _____	Chew on one side of mouth <input type="checkbox"/> Yes <input type="checkbox"/> No	Mouth breathing <input type="checkbox"/> Yes <input type="checkbox"/> No
City/State _____	Cigarette, pipe, or cigar smoking <input type="checkbox"/> Yes <input type="checkbox"/> No	Mouth pain, brushing <input type="checkbox"/> Yes <input type="checkbox"/> No
Date of dental visit _____	Clicking or popping jaw <input type="checkbox"/> Yes <input type="checkbox"/> No	Orthodontic treatment <input type="checkbox"/> Yes <input type="checkbox"/> No
Date of last dental X-rays _____	Dry mouth <input type="checkbox"/> Yes <input type="checkbox"/> No	Pain around ear <input type="checkbox"/> Yes <input type="checkbox"/> No
Place a mark on "Yes" or "No" to indicate if you have had any of the following:	Fingernail biting <input type="checkbox"/> Yes <input type="checkbox"/> No	Periodontal treatment <input type="checkbox"/> Yes <input type="checkbox"/> No
Bad breath <input type="checkbox"/> Yes <input type="checkbox"/> No	Food collecting between the teeth <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to cold <input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding gums <input type="checkbox"/> Yes <input type="checkbox"/> No	Foreign objects <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to heat <input type="checkbox"/> Yes <input type="checkbox"/> No
Blisters on lips or mouth <input type="checkbox"/> Yes <input type="checkbox"/> No	Grinding teeth <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to sweets <input type="checkbox"/> Yes <input type="checkbox"/> No
	Gums swollen or tender <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity when biting <input type="checkbox"/> Yes <input type="checkbox"/> No
	Jaw pain or tiredness <input type="checkbox"/> Yes <input type="checkbox"/> No	Sores or growths in your mouth <input type="checkbox"/> Yes <input type="checkbox"/> No
	Lip or cheek biting <input type="checkbox"/> Yes <input type="checkbox"/> No	How often do you floss? _____
		How often do you brush? _____

HEALTH HISTORY

Physician's Name _____ Date of last visit _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you wear contact lenses?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Weight Loss, unexplained	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis, Rheumatism	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fainting or dizziness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Radiation Treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Heart Valves	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Respiratory Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Joints	<input type="checkbox"/> Yes <input type="checkbox"/> No	Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No	Scarlet Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Back Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shortness of Breath	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding abnormally, with extractions or surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis Type _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sinus Trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Skin Rash	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Special Diet	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemical Dependency	<input type="checkbox"/> Yes <input type="checkbox"/> No	HIV Positive	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemotherapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaundice	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swelling of Feet or Ankles	<input type="checkbox"/> Yes <input type="checkbox"/> No
Circulatory Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaw Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swollen Neck Glands	<input type="checkbox"/> Yes <input type="checkbox"/> No
Congenital Heart Lesions	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cortisone Treatments	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tonsillitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cough, persistent or bloody	<input type="checkbox"/> Yes <input type="checkbox"/> No	Low Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mitral Valve Prolapse	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tumor or growth on head or neck	<input type="checkbox"/> Yes <input type="checkbox"/> No
Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Nervous Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcer	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	Venereal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No

WOMEN: Are you pregnant? Yes No Due date _____ Are you nursing? Yes No

To the best of my knowledge all of the information above is true and complete

Patient's Signature _____ Date _____ Relationship to Patient _____ Date _____

MEDICATIONS

List medications you are currently taking:

Pharmacy Name _____

Phone _____

ALLERGIES

<input type="checkbox"/> Aspirin	<input type="checkbox"/> Local Anesthetic
<input type="checkbox"/> Barbiturates (Sleeping pills)	<input type="checkbox"/> Penicillin
<input type="checkbox"/> Codeine	<input type="checkbox"/> Sulfa
<input type="checkbox"/> Iodine	<input type="checkbox"/> Other _____
<input type="checkbox"/> Latex	_____

UPDATES (To be filled in at future appointments)

Has there been any change in your health since your last dental appointment? Yes No

For what conditions? _____

Are you taking any new medications? _____ If so, what _____

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

.....
Has there been any change in your health since your last dental appointment? Yes No

For what conditions? _____

Are you taking any new medications? _____ If so, what _____

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

_____|_____|_____|_____|_____|_____|_____|_____|

PATIENT NUMBER

welcome

Patient's Name _____ Last _____ First _____ Initial _____ Date of Birth _____

CIRCLE THE APPROPRIATE ANSWER, IF YOU DON'T KNOW THE CORRECT ANSWER PLEASE WRITE "DON'T KNOW" ON THE LINE AFTER THE QUESTION

COMMENTS

1. Physician's Name _____
Address _____
Tel: (_____) _____
2. Are you under a physician's care?YES NO
Since when _____ Why _____
3. When was your last complete physical exam? _____
4. Are you taking any medication or substances?YES NO
(If yes, please list medications in comments section or on the back of this form.)
5. Do you routinely take health related substances? (Vitamins, herbal supplements, natural products) ..YES NO
6. Are you allergic to any medications or substances? (please list)YES NO
7. Do you have any other allergies or hives?YES NO
8. Do you have any problems with penicillin, antibiotics, anesthetics
or other medications?YES NO
9. Are you sensitive to any metals or latex?YES NO
10. Are you pregnant or suspect you may be?YES NO
11. Do you use any birth control medications?YES NO
12. Have you ever been treated for or been told you might have heart disease?YES NO
13. Do you have a pacemaker, an artificial heart valve implant, or
been diagnosed with mitral valve prolapse?YES NO
14. Have you ever had rheumatic fever?YES NO
15. Are you aware of any heart murmurs?YES NO
16. Do you have high or low blood pressure? (please circle)YES NO
17. Have you ever had a serious illness or major surgery?YES NO
If so, explain _____
18. Have you ever had radiation treatment, chemo treatment for tumor,
growth or other condition?YES NO
19. Have you ever taken Fosamax, Zometa, Aredia or any other oral or intravenous treatment
(bisphosphonates) for bone tumors, excessive calcium in your blood, or osteoporosis? ..YES NO
20. Do you have inflammatory diseases, such as arthritis or rheumatism?YES NO
21. Do you have any artificial joints/prosthesis?YES NO
22. Do you have any blood disorders, such as anemia, leukemia, etc?YES NO
23. Have you ever bled excessively after being cut or injured?YES NO
24. Do you have any stomach problems?YES NO
25. Do you have any kidney problems?YES NO
26. Do you have any liver problems?YES NO
27. Are you diabetic?YES NO
28. Do you have fainting or dizzy spells?YES NO
29. Do you have asthma?YES NO
30. Do you have epilepsy or seizure disorders?YES NO
31. Do you or have you had venereal or any sexually transmitted disease?YES NO
32. Have you tested HIV positive?YES NO
33. Do you have AIDS?YES NO
34. Have you had or do you test positive for hepatitis?YES NO
35. Do you or have you had T.B.?YES NO
36. Do you smoke, chew, use snuff or any other forms of tobacco?YES NO
37. Do you regularly consume more than one or two alcoholic beverages a day?YES NO
38. Do you habitually use controlled substances?YES NO
39. Have you had psychiatric treatment?YES NO
40. Have you taken any prescription drugs fenfluramine, fenfluramine combined with
phentermine (fen-phen), dexfenfluramine (redux), or other weight loss products?YES NO
41. Do you have any disease condition, or problem not listed? If so, explain _____
42. Is there anything else we should know about your health that we have not covered in this form?

43. Would you like to speak to the Doctor privately about any problem?YES NO

Large empty rectangular box for patient or provider comments.

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT'S / GUARDIAN'S SIGNATURE _____ DATE _____

DENTIST'S SIGNATURE _____ DATE _____

ANEST.

MED. ALERT

MEDICAL HISTORY

Adult Dentistry Of SWFL

Dr. Norma Jeanne Appelbaum
1519 SE 47th Terr, Cape Coral
(239) 549-6100

Health care costs must be controlled, we all agree. For that reason I charge reasonable and comparable fees for my services. However my billing lab fees and insurance filing fees have risen and continue to rise constantly. For that reason, rather than be forced to raise fees, I chose to reduce my costs by collecting fees at the time service is rendered. Therefore, payment is expected at the time of service.

For your convenience, I accept cash/debit cards, checks, Visa/MC, Discover, American Express. For those who require financing we work with Care Credit.

Your insurance may reimburse you for services rendered through this office but you must understand that my professional relationship is with you and not your insurance company. You are responsible, not the insurance company, for paying for my services. Because insurance payments are uncertain and slow, I cannot accept the promise of insurance coverage instead of payment. Since I cannot possibly know the provisions of each patients insurance policy, it is your responsibility to meet the requirements and limitations of your insurance coverage. I feel that if this is all understood, it will not become a financial stressor to our relationship later on.

ALL CROWN AND BRIDGE, REMOVABLE PARTIALS OR DENTURES MUST BE PAID FOR PRIOR TO DELIVERY

For appointments of 2 hours or more a NON REFUNDABLE \$500 deposit will be made to guarantee the time, this will be put toward the services done at that appointment unless the appointment is cancelled without 2 working days prior notice.

I have read and understand this policy and agree to abide by it _____ (initial)

I will be paying with _____ cash _____ credit/debit card _____ check

Signature

Date

PHI V A C Y P R A C T I C E S A C K N O W L E D G E M E N T

I have received the Notice of Privacy Practices, and I have been provided an opportunity to review it.

Name _____ Date of Birth _____

Signature _____

Date _____

_____ attempted to obtain patient's acknowledgement but was unable to do so. The reason it was not obtained was _____

Signature _____

Date _____