

Welcome to the Applecross Dental Clinic! Please take a few minutes to fill out this form to your best ability.
Feel free to approach our front desk staff members if you have any further questions or concerns.
Please write in the grey areas.

1 Patient Information

Name [First, Last]

Birthdate [d/m/y]

Address [Number, Street]

City, Postal Code

Home Phone

Cell Phone

Work Phone

Email Address

Who referred you to us?

Which Dentist do you prefer to see? [Choose 1]

Dr. Kwok Dr. Protzer Either

How should we contact you? [Choose 1+]

Phone Email Text

How nervous are you about seeing the Dentist?

0 1 2 3 4 5 6 7 8 9 10

2 Primary Insurance

Name of Policy Holder [First, Last]

Birthdate of Policy Holder [d/m/y]

Insurance Company

Employer

Insurance Plan Details [Please include your Group/Plan # and your ID#]

✔ Please provide us with a detailed copy of your primary insurance information

3 Secondary Insurance

Name of Policy Holder [First, Last]

Birthdate of Policy Holder [d/m/y]

Insurance Company

Employer

Insurance Plan Details [Please include your Group/Plan # and your ID#]

✔ Please provide us with a detailed copy of your secondary insurance information

4 Dental History

Former Dentist

Approx. Date of Last X-Rays [ex: 2 years ago]

How do you feel about the appearance of your teeth?

Please indicate if you have any of the following problems:

- | | | | | |
|--|--|---|--|---|
| <input type="checkbox"/> Bad Breath | <input type="checkbox"/> Clicking or Popping Jaw | <input type="checkbox"/> Jaw Pains | <input type="checkbox"/> Sensitivity When Biting | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Bleeding Gums | <input type="checkbox"/> Food Collection between Teeth | <input type="checkbox"/> Loose Teeth | <input type="checkbox"/> Sensitivity Hot/Cold | <input type="checkbox"/> Snoring |
| <input type="checkbox"/> Broken Fillings | <input type="checkbox"/> Grinding or Clenching Teeth | <input type="checkbox"/> Problems with Flossing | <input type="checkbox"/> Sensitivity Sweet/Sour | <input type="checkbox"/> Sores or Growths |

How would you like us to help you today?

Are you in dental discomfort today?

Do you consume lemon water or citrus fruits?

5 Medical History

Physician's Name

Medical Clinic

Have you had any serious illness or operations within your life?

Please list any medications you are currently taking

Please list any allergies that you have

Please indicate if you have, or have had, any of the following conditions:

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Acid Reflux | <input type="checkbox"/> Gout | <input type="checkbox"/> Mitral Valve Prolapse | Infectious Diseases |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> HIV or AIDS |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Hepatitis B or C |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Seizures/Epilepsy | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Artificial Valves | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Stroke | <input type="checkbox"/> Have you ever had a blood transfusion? |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Surgical Implants | <input type="checkbox"/> Have you ever used intravenous drugs or cocaine? |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Thyroid Problems | |
| <input type="checkbox"/> Breathing Problems | <input type="checkbox"/> Malignant Hyperthermia | <input type="checkbox"/> Tobacco Habit | For Women |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Material Allergies | | <input type="checkbox"/> Are you pregnant? |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Medication Allergies | | <input type="checkbox"/> Are you nursing? |

6 Authorization

I have reviewed the information on this questionnaire to the best of my knowledge.

I understand that this information will be used by my dentist to help determine appropriate dental care.

If there is any change in my medical status I will inform my dentist.

I authorize the use of this signature on all insurance submissions.

I authorize my dentist to release information contained in claims in order to secure the payment of benefits.

I hereby assign my dental benefits, payable from claims submitted, to my dentist and authorize payment directly to my dentist.

I understand that I am financially responsible for all charges whether or not paid by insurance.

I understand that payment is due when service is rendered.

I understand that "assignment" (my insurance paying my dentist directly for treatment) is accepted only as a courtesy.

I understand that missed or cancelled appointments are subject to a cancellation fee unless two (2) business days notice is given.

Signature

Date [d/m/y]