applecross dental
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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?

How nervous are you about seeing the Dentist? [Please circle]

0 1 2 3 4 5 6 7 8 9 10

How would you like to be contacted? [Check all that apply]

☐ Phone Call ☐ Email Reminder ☐ Text Reminder

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*

Please fill out the other side as well!

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:

- ☐ Bad Breath
- ☐ Bleeding Gums
- ☐ Broken Fillings
- ☐ Clicking or Popping Jaw
- ☐ Food Collection between Teeth
- ☐ Grinding or Clenching Teeth
- ☐ Jaw Pains
- ☐ Loose Teeth
- ☐ Problems with Flossing
- ☐ Sensitivity When Biting
- ☐ Sensitivity Hot/Cold
- ☐ Sensitivity Sweet/Sour
- ☐ Sleep Apnea
- ☐ Snoring
- ☐ 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:

- ☐ Acid Reflux
- ☐ Allergies
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Artificial Valves
- ☐ Asthma
- ☐ Bleeding Disorder
- ☐ Breathing Problems
- ☐ Cancer
- ☐ Diabetes
- ☐ Gout
- ☐ Heart Problems
- ☐ Heart Murmur
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ High Blood Pressure
- ☐ Malignant Hyperthermia
- ☐ Material Allergies
- ☐ Medication Allergies
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker
- ☐ Rheumatic Fever
- ☐ Seizures/Epilepsy
- ☐ Stroke
- ☐ Surgical Implants
- ☐ Thyroid Problems
- ☐ Tobacco Habit

Infectious Diseases

- ☐ HIV or AIDS
- ☐ Hepatitis B or C
- ☐ Tuberculosis
- ☐ Have you ever had a blood transfusion?
- ☐ Have you ever used intravenous drugs or cocaine?

For Women

- ☐ Are you pregnant?
- ☐ 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]