APPLE DENTAL

Thank you for choosing Apple Dental to take care of your dental healthcare needs. To help us meet all your dental healthcare needs, please fill out this form. If you have any questions or need assistance, please ask! We will be happy to help!

Date: _____

Patient Information

Name:_____

Date of Birth:_____ Social Security #_____

Address:_____ City:_____ State_____ ZIP_____

Home Phone_____CellPhone_____

Email:_____ Work Phone: _____

Circle Martial Status: MINOR SINGLE MARRIED DIVORCED WIDOWED SEPERATED

Patient or Parent's Employer: _____

Who may we that for referring you?_____

Person to contact in case of emergency _____Phone #

Responsible Party

Name of person responsible for this account? _____Relationship to patient _____

Address_____ Cell Phone_____

Employer_____ Date of Birth:_____

SSN_____

Is this person currently a patient in our office? YES NO

Insurance Information

Name of Insured_____ Relationship to Patient_____

Birthdate_____ Social Security_____ Name of Employer_____

Insurance Company_____ Insurance Phone #_____

Insurance Company Address_____ City_____ ZIP_____

Patient Dental History

Do your gums bleed while brushing or flossing? YES NO

Do you clench or grind your teeth? YES NO

Have you ever had a difficult extraction in the past? YES NO

Do you wear dentures or partials? YES NO

If yes please, date of placement _____

How do you feel about maintaining a healthy mouth?

_____

_____

How do you feel about the appearance of your teeth?

_____

_____

If you could change anything about your smile, what would you change?

_____

Medical History

Are you under a physician's care? YES NO _____

Have you ever been hospitalized or had a major operation? YES NO _____

Have you ever had a serious head or neck injury? YES NO _____

Are you taking any medications? YES NO _____

Do you take or have you taken PHen-Fen or Redux? YES NO _____

Do you take or have you taken Fosamax, Boniva Actonel or other medications containing bisphosphates? YES NO _____

Do you use tobacco? YES NO _____

Do you use controlled substances? YES NO _____

WOMEN: Are you? PREGNANT/TRYING TO GET PREGNANT ☐ NURSING ☐ TAKING ORAL CONTRACEPTIVES ☐

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING? PLEASE CIRCLE

Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics

Other: _____

- ○ AIDS/HIV Positive
- ○ Alzheimer's Disease
- ○ Anaphyla
- ○ Anemia
- ○ Angina
- ○ Arthritis/Gout
- ○ Artificial Heart Valve
- ○ Artificial Joint
- ○ Asthma
- ○ Blood Disease
- ○ Blood Transfusion
- ○ Breathing Problem
- ○ Bruise Easily
- ○ Cancer
- ○ Chemotherapy
- ○ Chest Pains
- ○ Cold Sores/Fever blisters
- ○ Congenital Heart Disorder
- ○ Convulsions
- ○ Cortisone Medicine
- ○ Diabetes
- ○ Drug Addiction
- ○ Easily Winded
- ○ Emphysema
- ○ Epilepsy or Seizures
- ○ Excessive Thirst
- ○ Fainting Spells/Dizziness
- ○ Frequent Cough
- ○ Frequent Diarrhea
- ○ Frequent Headaches
- ○ Genital Herpes
- ○ Glaucoma
- ○ Hay Fever
- ○ Heart Attack/Failure
- ○ Heart Murmur
- ○ Heart Pace Maker
- ○ Heart Trouble/Disease
- ○ Hemophillia
- ○ Hepatitis A
- ○ Hepatitis B or C
- ○ Herpes
- ○ High Blood Pressure
- ○ Hives or Rash
- ○ Hypoglycemia
- ○ Irregular Heartbeat
- ○ Kidney Problems
- ○ Leukemia
- ○ Liver Disease
- ○ Low Blood Pressure
- ○ Lung Disease
- ○ Mitral Valve Prolapse
- ○ Pain in Jaw Joints
- ○ Parathyroid Disease
- ○ Psychiatric Care
- ○ Radiation Treatment
- ○ Recent Weight Loss
- ○ Renal Dialysis
- ○ Rheumatic Fever
- ○ Rheumatism
- ○ Scarlet Fever
- ○ Shingles
- ○ Sickle Cell
- ○ Sinus Trouble
- ○ Sleep Apnea
- ○ Spina Biffida
- ○ Stomach Disease
- ○ Stroke
- ○ Swelling of Limbs
- ○ Thyroid Disease
- ○ Tonsilitis
- ○ Tuberculosis
- ○ Tumors or Growths
- ○ Ulcers
- ○ Venereal Disease
- ○ Yellow Jaundice
- ○ Other_____

1. Copy of Photo ID is requested upon arrival
2. Payment is due in full at the time of visit for patients without insurance
3. Payment of deductible and/or co-insurance is due at the time of the visit for patients with insurance.
4. We accept cash, check. Debit cards, credit cards. (Care Credit, Mastercard, Visa, Discover, and American Express)
5. We do NOT bill our, therefore the person bringing the patient is responsible for payment of the patient's visit.
6. Any balance not paid be the insurance company is your responsibility.
7. You agree to pay all attorney fees and collections cost incurred if account is turned over for non-payment.
8. You agree to pay monthly interest in amount of 1.5% of any unpaid balance.
9. Our office only uses state- of the art tooth colored resin fillings. Some insurance considers this cosmetic and downgrades it to the silver amalgam fillings. You are responsible for any difference that your insurance does not cover.

I, _____, understand and agree to the above payment policy.

Signature: _____ Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____

Please PRINT Name

_____

Signature

_____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our notice of privacy practices, but acknowledgement could not be obtained because:

- o Individual refused to sign
- o Communication barriers prohibited obtaining the acknowledgment
- o An emergency prevented us from obtaining acknowledgment.
- o Other (specify)

_____

_____

_____

CONSENT FOR DENTAL TREATMENT AND ACKNOWLEDGMENT OF RECEIPT OF INFORMATION

State law requires to obtain your consent for the contemplated dental treatment. What you are being asked to sign is confirmation that we have discussed the nature and purpose of your contemplated treatment and the risks associated therewith. Ask about anything you do not understand. We will be pleased to explain.

I hereby authorized and direct DR MATT SANDERSON OR DR KEVIN HAYNES OR DR KALEB WILLIAMSON with associated or assistance of his choice to perform upon _____ _____the following diagnostic, surgical or dental procedures:

_____

_____

Including any necessary or advisable anesthesia.

ALTERNATIVES TO THE RECOMMENDED DENTAL TREATMENT:

Alternatives to the recommended treatment, including no treatment, have been explained to times as have the advantages and disadvantages of each.

RISKS ASSOCIATED WITH THE RECOMENDED DENTAL TREATMENT:

I understand that dentistry is not an exact science, and the complications may occur despite our best efforts. A partial listing of the risks known to be associated with this treatment and with the associated anesthetic are:

- Swelling & bruising which may necessitate staying home for several days
- Retained instrument fragments
- Paresthesia (permanent or transient numbness of the cheeks, gums, teeth lips, tongue, chin, and face)
- Change of bite
- Loss of taste
- Swallowing of objects
- Aspiration of objects
- Drug/Allergic Reactions
- Dry socket, delayed healing
- Stretching of mouth which may result in cracking or bruising
- Failure of the treatment to accomplish its purpose
- Bleeding with may be heave enough to stop the procedure
- Instrument breakage
- Infection
- Pain
- Breakage of Roots
- Retained Root Fragments
- Loss/Damage to adjacent teeth and bone
- Fracture of breakage of jaw
- Sinus involvement
- TMJ Dysfunction or worsen of TMJ condition.
- Trismus (jaw pain of difficulty opening mouth further for treatment)

State law also requires that I specifically advise you that, although rarely occurring, the dental treatment or anesthetic may result in: Death, Brain damage, Quadriplegia, Paraplegia, Loss of organs, Loss of function of an organ, Loss of function of face, arms, or legs and disfiguring scars:

ACKNOWLEDGEMENT

I acknowledge that I have read and I understand the information on both pages of this consent form (or that it has been read to me) I understand the information contained in it; including all of the technical terms about which I have asked if unsure, I have been given an adequate opportunity to ask whatever questions I had about the treatment. All the questions about the treatment have been answered in a satisfactory manner.

I understand that the success of this treatment and the avoidance of treatment complications depends to an extent upon my complying with the oral hygiene and dietary restrictions that have been explained to me, if by following the instructions given to me, and my keeping the appointments for treatment or follow-up office visits scheduled or recommended. I also understand that I am to notify the dentist immediately of any suspected complications, where further treatment may be discussed, or administered, which is not currently anticipated.

I hereby authorize and direct DR MATT SANDERSON or DR KEVIN HAYNES or DR KALEB WILLIAMSON and or associates/assistants of his choice, to perform the diagnostic, surgical or dental treatments. This consent form will remain valid until revoked by me in writing. All blanks were filled in prior to my signature, I waive any further disclosures of information.

DATE _____

Signature of Patient: X_____

Signature of Relative/Guardian X_____

Signature of Witness X_____

_____

Dentist

Appointment Reminder Consent

Complete the form and sign below to give your permission for Apple Dental to provide an automated appointment reminder service by email or by cell phone test message.

_____ Apple Dental may send email message to confirm my upcoming appointments. Email_____

_____ Apple Dental may send cell phone test messages to confirm my upcoming appointments. Cell Phone number_____

_____ I do not want email or text message reminders.

_____ I do not have an email address, or ability to get text message reminders, please call me for reminders. Phone Number _____

_____
Signature of Patient or Guardian

_____
Date