Apple Valley Dental Group PLC

Harry M. Sartelle III DDS PC • Paul G. Byers DDS MS

PATIENT INFORMATION

DATE ______________________

NAME ____ ❒ MARRIED ❒ SINGLE ❒ MINOR
LAST FIRST M.I.

ADDRESS ____ ❒ MALE ❒ FEMALE

BIRTHDATE ______________ AGE ______ TELEPHONE ________________ / ________________
MO. DAY YR. HOME WORK

EMPLOYER ____

OCCUPATION ____

ADDRESS ________________________________ S.S.# ________________

CELL PHONE ________________________ EMAIL ________________________

DENTAL INSURANCE CO. ________________________ GROUP NO. ________________

HAS ANY MEMBER OF YOUR FAMILY EVER BEEN TREATED IN OUR OFFICE? ❒ YES ❒ NO

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? ________________________

PATIENT INFORMATION

SPOUSE/PARENT	CHILDREN	
	NAME	AGE
NAME ______________	1. ______________	______
ADDRESS ______________	2. ______________	______
TELEPHONE ______________	3. ______________	______
BIRTHDATE __________ S.S.# __________	4. ______________	______
EMPLOYER ______________	5. ______________	______
OCCUPATION ______________	6. ______________	______
DENTAL INSURANCE CO. ______________		
GROUP# ______________		

PERSON RESPONSIBLE FOR ACCOUNT

CHECK ONE ❑ Patient ❑ Father/Husband ❑ Mother/Wife ❑ Guardian

EMERGENCY CONTACT (OUTSIDE OF IMMEDIATE FAMILY)

NAME ________________________ TEL.# ________________
LAST FIRST M.I.

ADDRESS ____
STREET CITY STATE ZIP

MEDICAL HISTORY

MEDICAL DOCTOR'S NAME ________________________ PHONE NUMBER ________________

❑ YES ❑ NO ARE YOU CURRENTLY UNDER A DOCTOR'S CARE? WHY? ________________

____

❑ YES ❑ NO HAVE YOU BEEN HOSPITALIZED IN THE LAST TWO YEARS? WHY? ________________

____

OVER

❒ YES ❒ NO ARE YOU TAKING ANY PILLS, MEDICATIONS, AND/OR DRUGS? WHAT KIND?

____

____

❒ YES ❒ NO DO YOU HAVE ANY ALLERGIES OR ARE YOU ALLERGIC TO ANY MEDICATIONS? WHAT KIND?

____

____

❒ YES ❒ NO DO YOU TAKE ASPIRIN ON A DAILY BASIS? HOW MUCH?

____

____

❒ YES ❒ NO DO YOU TAKE VITAMINS? WHAT KIND?

____

DOCTOR'S NOTES:

PLEASE *CIRCLE* IF YOU HAVE ANY OF THE FOLLOWING:

Heart Trouble
High Blood Pressure
Low Blood Pressure
Mitral Valve Prolapse
Heart Murmur
Rheumatic Fever
Congenital Heart Lesion
Artificial Heart Valve
Heart Pacemaker
Heart Surgery
Blood Disease
Anemia
Chest Pain
Birth Control Medicine

Tuberculosis
Liver Disease
Hepatitis A (infec)
Hepatitis B (serum)
Hepatitis C
Cancer
Parathyroid Disease
Chemotherapy/Radiation
Arthritis/Gout
Rheumatism
Pain in Jaw Joints
Epilepsy/Seizures
Nervousness
Bleeding Disorder

Shortness of Breath
Fainting or Dizziness
Stroke
Diabetes
Artificial Joints/Hips
Kidney Trouble
Ulcers
Allergies
Asthma
Hay Fever
Sinus Trouble
Emphysema
Lung Disease

Hypoglycemia
Psychiatric Care
Drug Addiction
Alcoholism
Blood Transfusion
Hemophilia
AIDS/HIV Positive
Venereal Disease
Fever Blisters
Herpes
Pregnancy
Smoking
Excessive Bleeding

❒ YES ❒ NO HAVE YOU EVER HAD ANY OTHER SERIOUS ILLNESS NOT CIRCLED?
DESCRIBE IN DETAIL ______________________________

____

❒ YES ❒ NO DO YOU WISH TO TALK TO THE DOCTOR PRIVATELY ABOUT ANY PROBLEMS?

METHOD OF PAYMENT

- ❒ PAYMENT IN FULL AT EACH APPOINTMENT
- ❒ PAYMENT OF NON-INSURANCE PORTION AT EACH APPOINTMENT
- ❒ MONTHLY PAYMENTS/PAYMENT PLANS (PRIOR ARRANGEMENTS MUCH BE MADE).

FINANCE CHARGE: If I do not pay the entire New Balance within 60 days of the monthly billing date, a FINANCE CHARGE will be added to the account for the current monthly billing cycle. The FINANCE CHARGE will be a periodic rate of 1.5% per month (or a minimum charge of $3.00 for a balance under $200.00) which is an ANNUAL PERCENTAGE RATE of 18% applied to the last month's balance. In the case of default of payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection on this account.

AUTHORIZATION

I hereby authorize payment directly to Apple Valley Dental Group of the group benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize Harry M. Sartelle III DDS or Paul G. Byers DDS MS to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary to proper dental care. The information on this page and the medical history are correct to the best of my knowledge.

X ______________________________ DATE ______________

❒ Adult Patient ❒ Father/Husband ❒ Mother/Wife ❒ Guardian

MEDICAL HISTORY UPDATE

I have read my medical history dated ________ and confirmed that it states past and present medical conditions. ______________ Signature ________ Date

I have read my medical history dated ________ and confirmed that it states past and present medical conditions. ______________ Signature ________ Date

I have read my medical history dated ________ and confirmed that it states past and present medical conditions. ______________ Signature ________ Date