540 White Pond Dr. I Akron, OH 4420
330.869.9090 I www.mikeappeldds.com

Patient Information

Date ____________________ Soc. Sec. # ____________________________ Birthdate ____________________

Name ____ Home Phone __________________________

Address ____ Cell Phone __________________________

City _______________________ State _______ Zip ___________ E-mail _______________________________

Sex: M F Minor Single Married Long-term Partner Divorced Widowed Separated

Employer ____ Business Phone __________________________

Business Address ____ Occupation __________________________

Who should we thank for referring you? ____

In case of emergency, who should we contact? ______________________ Phone ______________________

Primary Insurance

Person Responsible for Account ____

Relationship to Patient ________________ Birthdate ___________ Soc. Sec. # _______________________

Address ____ Home Phone _________________________

City ____ State _______ Zip __________________

Responsible Party Employed By _________________________ Business Phone ________________________

Insurance Company ____

Insurance Company Address ____

Subscriber I.D. # ____ Group # _____________________________

Additional Insurance

Insured Name ____

Relationship to Patient ________________ Birthdate ___________ Soc. Sec. # _______________________

Address ____ Home Phone _________________________

City ____ State _______ Zip __________________

Responsible Party Employed By _________________________ Business Phone ________________________

Insurance Company ____

Insurance Company Address ____

Subscriber I.D. # ____ Group # _____________________________

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Dental History

Former Dentist ______________________________ Date of Last X-Rays ________________________

City, State ___________________________________ How Often Do You Floss? ___________________

Date of Last Dental Visit ______________________ How Often Do You Brush? ___________________

Please check all that apply:

Bad Breath	Loose Teeth or Broken Fillings	Sensitivity to Sweets
Bleeding Gums	Orthodontic Treatment	Sensitivity When Biting
Blisters on Lips or Mouth	Pain Around Ear	Frequent Headaches
Finger Nail Biting	Periodontal Treatment	Jaw, Head or Neck Injuries
Grinding Teeth	Sensitivity to Cold	Jaw Difficulty (Clicking/Pain)
Lip or Cheek Biting	Sensitivity to Heat	Tooth Pain

Medical History

Physicians Name ____ Date of Last Visit __________________

1. Are you currently under medical treatment?
2. Have you every had any serious illnesses or operations?
3. Are you currently taking any medication?

   Please describe: ____
4. Do you smoke?
5. Do you use alcohol, cocaine or other drugs?
6. Do you wear contact lenses?
7. Have you ever had an allergic reaction to the following: (check all that apply)

Penicillin or other Antibiotics	Sulfa Drugs	Barbiturates	Aspirin
Sedatives	Iodine	Other: __________________________	
8. (Women Only) Are You: (check all that apply)

   Pregnant Nursing Taking Birth Control Pills

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Please check all that apply:

- Aids
- Anemia
- Arthritis, Rheumatism
- Artificial Heart Valves
- Artificial Joints
- Asthma
- Back Problems
- Bleeding abnormally with extraction or surgery
- Blood Disease
- Cancer
- Chemical Dependency
- Chemotherapy
- Chronic Fatigue Syndrome
- Circulatory Problems
- Congenital Heart Lesions
- Cortisone Treatments
- Cough- persistent or bloody
- Diabetes
- Emphysema
- Epilepsy
- Fainting or Dizziness
- Glaucoma
- Headaches
- Heart Murmur
- Heart Problems
- Hepatitis-Type
- Herpes
- High Blood Pressure
- HIV Positive
- Jaundice
- Jaw Pain
- Kidney Disease
- Latex Sensitivity
- Liver Disease
- Low Blood Pressure
- Mitral Valve Prolapse
- Nervous Problems
- Pacemaker
- Psychiatric Care
- Radiation Treatment
- Respiratory Disease
- Rheumatic Fever
- Scarlet Fever
- Shortness of Breath
- Sinus Trouble
- Skin Rash
- Stroke
- Swelling of Feet/Ankles
- Swollen Neck Glands
- Thyroid Problems
- Tonsillitis
- Tuberculosis
- Tumor/Growth on Head/Neck
- Ulcer
- Venereal Disease

Assignment and Release

I hereby authorize payment directly to ________________________ for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

I authorize the above doctor and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party ____ Date ______________