G. Michael appel DDS LLC
FAMILY DENTISTRY
554 White Pond Dr. | Akron, OH 4420
330.869.9090 | 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 # _____

G. Michael Appel DDS LLC
FAMILY DENTISTRY
554 White Pond Dr. | Akron, OH 4420
330.869.9090 | www.mikeappeldds.com

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

G. Michael appel DDS LLC
FAMILY DENTISTRY
554 White Pond Dr. | Akron, OH 4420
330.869.9090 | www.mikeappeldds.com

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 _____