# WELCOME TO OUR PRACTICE!

## PATIENT INFORMATION (CONFIDENTIAL)

Name: _____ DOB: _____ SS#: _____

Address: _____ City: _____ St.:_____ Zip: _____

How would you like to be contacted? Cell#: _____ Home#:_____

Other (mail/e-mail): _____ Gender: Female ☐ Male ☐

Marital Status: ☐ Minor ☐ Single ☐ Married ☐ Long Term Partner ☐ Divorced ☐ Widowed ☐ Separated

Employer Name: _____ Phone#: _____

Spouse or Partner Name: _____ Cell#: _____

Full Time Student? YES NO Name of School: _____

**Person to contact in case of Emergency** _____ **Phone:** _____

**Who may we thank for referring you?** _____

### IF PATIENT IS A MINOR- COMPLETE THIS SECTION

Mother/ Guardian: _____ Father/ Guardian: _____

Date of Birth: _____ Date of Birth: _____

Phone/Cell#: _____ Phone/Cell#: _____

Employer Name: _____ Employer Name: _____

Employer Phone#:_____ Employer Phone#: _____

### INSURANCE INFORMATION

Name of Insured: _____ Relationship to Patient: _____

Birthdate: _____ SSN#/ SIN: _____

Insurance Company: _____ Group#_____ Policy/ID #_____

### SECONDARY INSURANCE INFORMATION (IF APPLICABLE)

Name of Insured: _____ Relationship to Patient: _____

Birthdate: _____ SSN#/ SIN: _____

Insurance Company: _____ Group#: _____ Policy/ ID #: _____

I hereby authorize payment of insurance benefits directly to Apple Dental otherwise payable to me. I understand that my dental insurance carrier or payer of my dental benefits may **pay less** than the actual bill for services. **I understand I am financially responsible** for payments in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payments of services not paid, in whole or in party by my dental care payer.

**I ATTESTST TO THE ACCURACY OF THE INFORMATION ON THIS PAGE**

**Signature of Patient/Parent/Guardian**_____ **Date**_____

Patient Name: _____ Previous Dentist: _____

# PATIENT MEDICAL HISTORY

| | | |
|---|---|---|
| Allergies (seasonal)..... | YES | NO |
| Anemia..... | YES | NO |
| Arthritis..... | YES | NO |
| Asthma..... | YES | NO |
| Cancer..... | YES | NO |
| Cardiac pacemaker..... | YES | NO |
| Chemotherapy..... | YES | NO |
| Diabetes..... | YES | NO |
| Emphysema..... | YES | NO |
| Epilepsy/ Convulsions..... | YES | NO |
| Fainting..... | YES | NO |
| Glaucoma..... | YES | NO |
| High Cholesterol..... | YES | NO |
| Heart Attack..... | YES | NO |
| Heart Condition..... | YES | NO |
| Heart Murmur..... | YES | NO |
| Hemophilia..... | YES | NO |
| Hepatitis A,B,C (other) ..... | YES | NO |
| High Blood Pressure..... | YES | NO |
| HIV/ AIDS..... | YES | NO |
| Joint/ Artificial Replacement..... | YES | NO |
| Kidney Disease..... | YES | NO |
| Liver Disease ..... | YES | NO |
| Low Blood Pressure..... | YES | NO |
| Mitral Valve Prolapse..... | YES | NO |
| Osteoporosis..... | YES | NO |
| Psychiatric Problems/ History..... | YES | NO |
| Radiation Therapy..... | YES | NO |
| Respiratory Problems..... | YES | NO |
| Rheumatic Fever..... | YES | NO |
| Seizures..... | YES | NO |
| Shingles..... | YES | NO |
| Sickle Cell Disease..... | YES | NO |
| Stomach Troubles/ Ulcer..... | YES | NO |
| Stroke..... | YES | NO |
| Thyroid Problem..... | YES | NO |
| Tuberculosis..... | YES | NO |
| ADHD/AUTISM..... | YES | NO |
| Herpes..... | YES | NO |

Other Condition(s) not listed: _____

1. Are you under medical treatment now?.....YES NO

2. Have you ever been hospitalized for ..... YES NO
any surgical operations or serious illness
within the last 5 years? If **YES,** please explain_____
_____

3. Are you taking any medication(s)?
Including non- prescription medicine?.....YES NO
**If yes what medication(s) are you taking?** _____
_____
_____

4. Have you ever taken Fen- Phen/ Redux? ..... YES NO

5. Have you ever taken Fosamax, Boniva,
Actonel or any cancer medication
Containing Bisphosphonates? ..... YES NO

6. **Have you been advised by your Medical Doctor that you need pre medication before any dental treatment?** YES NO

7. **Are you allergic to or have you had Any reactions to the following?**

| | | |
|---|---|---|
| Dental Anesthetics (example: Novocain) .....YES | | NO |
| Metals (example: nickel, mercury, jewelry)..... YES | | NO |
| Latex Rubber..... YES | | NO |
| Codeine..... YES | | NO |
| Aspirin.....YES | | NO |
| Erythromycin.....YES | | NO |
| Sulfa.....YES | | NO |
| **Penicillin** or any other antibiotics?.....YES | | NO |

Other (please list) _____

8. Do you use tobacco? ..... YES NO

9. Do you have history of drug/ alcohol
or controlled substance abuse? .....YES NO

10. Do you use controlled substances?
(example: morphine, Vicodin, etc.) .....YES NO

11. **Woman only:**
Are you pregnant or think you
may be pregnant? .....YES NO

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (patient's) health. It is my responsibility to inform the dental office of any changes in medical status. I authorize the dentist to perform diagnostic/preventative procedures and treatment as may be necessary for proper dental care. I authorize the release of any information concerning my (or my child's) health care, advice, and treatment provided for the purpose of evaluating and administering claim for insurance benefits. I authorize the release of any information concerning my (or my child's) health care, advice, and treatment to another dentist.

**I ATTEST TO THE ACCURACY OF THE INFORMATION ON THIS PAGE.**

**Signature of Patient/Parent/Guardian**_____ **Date**_____

# Apple Dental
## Ahmed R. Megally Dental Corp.
### Office Policies & Notice of Privacy Practice

1. Appointments cancelled **REQUIRE 24-Hour** advance notice.
2. The first missed appointment will result in $50.00 charge to your account. This is not billable to your insurance.
3. The **third** missed appointment will result in a dismissal from our office.
4. If you have a change of address, phone number, or insurance information, please notify us **immediately** so we can update the information in your file. If we do not have the correct information in your file you may be held responsible for payment of the entire account regardless of insurance coverage.
5. Any phone number and address provided by patient/parent/guardian will be used to contact you/patient in any necessary way.
6. Please read and check your monthly statement carefully. If you do not receive your billing statements by the 15th of the month, please call our office.
7. **PAYMENT IS REQUIRED AT THE TIME OF SERVICE.** Available methods of payment are Visa/MasterCard, Cash, Personal Checks and American Express. If you have dental insurance, we will bill them for you. However, you are responsible for immediately providing our office with all of your claim information. If you're insurance requires a co-payment it will be due at the time of service.
8. The following policy will be strictly enforced: Accounts not paid within 60 days will be considered overdue and appropriate action will be taken; your account will be sent to a private collection agency (unless specific arrangements have been made). Overdue accounts are then subject to a 1.5% monthly interest charge thereafter until the account has been paid. If it is necessary to refer your account to an outside collection agency you may be charged an additional fee of up to 50% of your account balance for costs we incur for utilizing a third party collection agency. There is a service charge of $25.00 for any returned checks.
9. We do Reserve the right to refuse service to anyone, but we will not discriminate based upon gender or race.
10. I have seen the Notice of Privacy Practice, and upon request we can give you a copy. I have seen the Dental Material Fact Sheet. I understand and agree that there are security cameras on the premises for safety and legal purposes. I am aware that Ahmed R. Megally Dental Corp. will be billing my insurance and receiving payment.

**I have read the above and agree to abide by the policies set forth in this office.**

_____ _____

Signature of Self, Parent, or Guardian Date