



DATE _____

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PATIENT INFORMATION

First Name _____ M.I. _____ Last Name _____ Birthdate _____

(Check all that applies) Sex: Male Female Minor Single Married

Street Address _____ City _____ State _____ Zip _____

E-Mail _____ For future appt. reminders, I prefer to be notified via text email phone call

Cell Phone _____ Home Phone _____ Work Phone _____

Employer _____

Driver's License Number _____ State _____ Social Security Number _____

Names of family members who are patients here at An Apple A Day Family Dentistry _____

Whom may we thank for referring you to our office? _____

In case of emergency, who should be notified?

Name _____ Phone _____ Relationship to Patient _____

Payment Method Cash Credit Card/Debit Card Care Credit I _____ hereby authorize assignment of my insurance rights and benefits directly to An Apple A Day Family Dentistry for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company.

PERSON RESPONSIBLE FOR THIS ACCOUNT

Check here if address is same as above

(If patient is a minor under 18, please complete the next section for the child's parent/guardian)

Name _____ Relationship to Patient _____ Birthdate _____

Home Address (if different from above) _____

Employer _____ Social Security Number _____ Driver's License Number _____

Payment Method Cash Credit Card/Debit Card Care Credit I _____ hereby authorize assignment of my insurance rights and benefits directly to An Apple A Day Family Dentistry for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company.

INSURANCE INFORMATION

SECONDARY INSURANCE INFORMATION

Dental Insurance Yes _____ No _____ Effective Date _____

Dental Insurance Yes _____ No _____ Effective Date _____

Subscriber's Name _____

Subscriber's Name _____

Subscriber's Birthdate _____

Subscriber's Birthdate _____

Subscriber's Employer _____

Subscriber's Employer _____

Insurance Company _____

Insurance Company _____

ID#/SS# _____ Insurance Ph. _____

ID#/SS# _____ Insurance Ph. _____

DENTAL HISTORY

Name of your former dentist _____ City/State _____

Approximate date of last appointment _____ Reason for first visit with us _____

Please add anything that you feel is important for the doctor to know _____

Please fill in the yes or no circle to the following questions.

YES NO Is this your **FIRST VISIT** to any dentist?

YES NO Are you having **PAIN, SWELLING, or SORE SPOTS** at this time?

YES NO Have you had and **COMPLICATIONS** with dental treatment?

YES NO Do your **GUMS BLEED**?

YES NO Have you been treated for **TMJ** (Temporomandibular joint) problems)?

YES NO Have you had **GUM TREATMENTS**?

Where do you rate your **current** level of dental health?

YES NO Do you have **REMOVABLE** dentures or partials?

1 2 3 4 5 6 7 8 9 10

Upper _____ Lower _____

poor average excellent

YES NO Do you have **BAD BREATH**?

YES NO Do you have a **FEAR** of Dentistry? If yes, why? _____

MEDICAL HISTORY

Name of Your Primary Care Physician _____ Phone _____ Date of last physical _____

Are you taking any MEDICATIONS now (PRESCRIPTION AND/OR OVER-THE-COUNTER)? Yes No

If yes, please list _____

Are you under a physician's care now? Yes No _____

Have you ever been hospitalized or had major operation? Yes No _____

Have you ever had a serious head or neck injury? Yes No _____

Have you ever taken Fosamax, Boniva, Actonel, Aredia, Zometa, Didronel, Bonefos, or any other medications containing bisphosphonates? Yes No _____

Are you on a special diet? 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? Acrylic Aspirin Codeine Latex Local Anesthetic Metals
 Penicillin Sulfa Other _____

Are you currently taking Coumadin, Warfarin or other blood thinners? Yes No _____

Do you have or have had at any time, any of the following? * Conditions may require medication

- | | | | | |
|--|--|--|--|---|
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Cancer | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> AIDS/HIV Positive | <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Heart Attack/Failure | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Stomach/Intestinal Disease |
| <input type="checkbox"/> Alzheimer's Disease | <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Anaphylaxis | <input type="checkbox"/> Cold Sores/Fever Blisters | <input type="checkbox"/> Heart Pace Maker | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Trouble/Disease | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Tonsilitis |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Pain in Jaw Joints | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Arthritis/Gout | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Hepatitis B or C | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Tumors or Growths |
| <input type="checkbox"/> Artificial Heart Valve* | <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Herpes | <input type="checkbox"/> Radiation Treatments | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Artificial Joint* | <input type="checkbox"/> Bleeding Problems | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Rheumatic Fever* | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Excessive Thirst | <input type="checkbox"/> Hives or Rash | <input type="checkbox"/> Rheumatism | |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Fainting Spells/Dizziness | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Scarlet Fever | |
| <input type="checkbox"/> Breathing Problem | <input type="checkbox"/> Frequent Cough | <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Shingles | |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Sickle Cell Disease | |

Have you ever had any serious illness not listed above? Yes No _____

Additional information about your health that we at An Apple A Day Family Dentistry should know? _____

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 (or patient's) health. It is my responsibility to inform An Apple A Day Family Dentistry of any changes in medical status.

Signature of Patient, Parent, or Guardian _____ Today's Date: _____

Dentist's Signature _____ Date: _____