

# Welcome to our office

Appleby Dental Clinic  
Dr. David. Kim

## Patient Information

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Last, First MI (Preferred Name)

Gender: \_\_\_\_\_ Family Status: \_\_\_\_\_

Birth Date: \_\_\_\_\_

Phone (Home): \_\_\_\_\_ (Work): \_\_\_\_\_ Ext: \_\_\_\_\_ Cell: \_\_\_\_\_

Email: \_\_\_\_\_

Address: \_\_\_\_\_  
Street Apartment #

City Province Postal Code

How do you prefer to be contacted? Phone(home) / Work / Cell / Email

## Dental Insurance

Group policy #  
Insurance company  
Name of Insured  
D.O.B

Certificate ID#

Health Spending accounts are to be remitted by patient. Our office is unable to remit on your behalf

## Health Information

Date of Last Dental Visit: \_\_\_\_\_ Reason for this visit: \_\_\_\_\_

Have you ever had any of the following? Please check those that apply:

- |  |  |   |   |
|--|--|---|---|
| <input type="checkbox"/> AIDS              | <input type="checkbox"/> Excessive Bleeding  | <input type="checkbox"/> Liver Disease        | <input type="checkbox"/> Stroke             |
| <input type="checkbox"/> Allergies _____   | <input type="checkbox"/> Fainting            | <input type="checkbox"/> Mental Disorders     | <input type="checkbox"/> Tuberculosis       |
|  | <input type="checkbox"/> Glaucoma            | <input type="checkbox"/> Nervous Disorders    | <input type="checkbox"/> Tumors             |
| <input type="checkbox"/> Anemia            | <input type="checkbox"/> Growths             | <input type="checkbox"/> Pacemaker            | <input type="checkbox"/> Ulcers             |
| <input type="checkbox"/> Arthritis         | <input type="checkbox"/> Hay Fever           | <input type="checkbox"/> Pregnancy            | <input type="checkbox"/> Venereal Disease   |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Head Injuries       | Due date: _____                               | <input type="checkbox"/> Codeine Allergy    |
| <input type="checkbox"/> Asthma            | <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Radiation Treatment  | <input type="checkbox"/> Penicillin Allergy |
| <input type="checkbox"/> Blood Disease     | <input type="checkbox"/> Heart Murmur        | <input type="checkbox"/> Respiratory Problems | OTHER:                                      |
| <input type="checkbox"/> Cancer            | <input type="checkbox"/> Hepatitis           | <input type="checkbox"/> Rheumatic Fever      | <input type="checkbox"/> _____              |
| <input type="checkbox"/> Diabetes          | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Rheumatism           |   |
| <input type="checkbox"/> Dizziness         | <input type="checkbox"/> Jaundice            | <input type="checkbox"/> Sinus Problems       | <input type="checkbox"/> _____              |
| <input type="checkbox"/> Epilepsy          | <input type="checkbox"/> Kidney Disease      | <input type="checkbox"/> Stomach Problems     |   |

- Have you ever had any complications following dental treatment?  Yes  No

If yes, please explain: \_\_\_\_\_

- Have you been admitted to a hospital or needed emergency care during the past two years?  Yes  No

If yes, please explain: \_\_\_\_\_

- Are you now under the care of a physician?  Yes  No

If yes, please explain: \_\_\_\_\_

- Name of Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

- Do you have any health problems that need further clarification?  Yes  No

If yes, please explain: \_\_\_\_\_

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Date: \_\_\_\_\_

Signature of patient, parent or guardian

### Referral Information

Whom may we thank for referring you to our practice?  Patient, friend  Yellow Pages  Sign  Work  Website

Name of person or office referring you to our practice: \_\_\_\_\_

### Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

Patients who carry dental insurance understand that all dental services rendered are charged directly to the insurance company and that he or she is personally responsible for co payment & deductibles of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

Past due accounts over 90 days will be subject to a credit charge or forward to a third party collection agency.

I have read the above conditions of treatment and payment and agree to their content.

\_\_\_\_\_  
Signature of patient, parent or guardian      Date: \_\_\_\_\_      Relationship to Patient: \_\_\_\_\_

\_\_\_\_\_  
Signature of guarantor of payment/responsible party      Date: \_\_\_\_\_      Relationship to Patient: \_\_\_\_\_