The Comfortable Choice For Your Entire Family

Apple Tree Dental Center

New Patient Enrollment Form

We will need to gather some information in order to begin a new patient record. The information gathered below is strictly confidential and will be used for internal office use and insurance purposes only.

Todays' Date: _____ Date Of Birth: _____

First Name: _____ Last Name: _____

Please check: Male ☐ Female ☐ SSN: _____

Address: _____
Street City Zip

Phone Numbers: Home: _____

Cell: _____

Work: _____

E-mail: _____

Employer: _____

☐ Please check this box if you would allow us to send appointment reminders via **text message** and **email** in the future. We assure your confidentiality and your address will remain secure within our practice and not be shared with any third party.

Spouse name: _____ Date of Birth: _____ SSN: _____

Spouse's Employer: _____ Phone Number: _____

Emergency Contact: _____
Name Relationship Number

How did you hear about us? Please check all that apply:

Friend or family ☐ Name: _____, Insurance Company ☐, Website ☐

Google ☐ Drive by/ Sign ☐, Facebook ☐, Kroger ☐, Lakota East HS ☐, Other: _____

Dental Insurance information

Insurance Co _____ Group #_____Phone#: _____

Insured name_____DOB:_____SSN:_____

If you have dental insurance, please provide all pertinent information to our front office personnel for verification. Apple Tree Dental Center accepts most dental plans and we are preferred providers for many companies.

Remember, your dental insurance is a contract between your employer and the dental insurance company. It is ultimately your responsibility to know the details of your plan.
We will always help you with any questions you may have.

Patient's Name: _____

DENTAL HISTORY

Please check any of the following problems that apply to you.	Yes	No
-Sensitivity (hot; cold, sweet, pressure)	☐	☐
Where? UR LR UL LL		
-Headaches, earaches, neck pain	☐	☐
-Jaw joint pain	☐	☐
-Teeth or fillings breaking	☐	☐
-Grinding or clenching teeth	☐	☐
-Bleeding, swollen or irritated gums	☐	☐
-Loose, tipped or shifting teeth	☐	☐
-Bad breath	☐	☐
Do you have or have you had any of the following?		
-Dentures	☐	☐
-Partial dentures	☐	☐
-Braces	☐	☐
-Periodontal (gum) treatments	☐	☐

Please share the following dates:

- Your last cleaning _____ /_____
- Your last oral cancer screening _____ /_____
- Your last complete X-Rays _____ /_____

Name of Previous Dentist _____

City _____ State _____

Phone Number _____

	Yes	No
If you could whiten your teeth for a cost anyone could afford, would you do it?	☐	☐
Do you smoke or use chewing tobacco?	☐	☐
How much?_____ For how long? _____		
If I could change my smile, I would:		
-Make it whiter	☐	☐
-Make it straighter	☐	☐
-Close spaces	☐	☐
-Replace black metal fillings with tooth colored restorations	☐	☐
-Repair chipped teeth	☐	☐
-Replace missing teeth	☐	☐
-Replace old crowns that don't match	☐	☐
-Have a smile makeover	☐	☐

ON A SCALE OF 1-10, WITH 10 BEING THE HIGHEST RATING:

How important is your dental health to you?

1 2 3 4 5 6 7 8 9 10

Where would you rate your current dental health?

1 2 3 4 5 6 7 8 9 10

Where do you want your dental health to be?

1 2 3 4 5 6 7 8 9 10

Why did you leave your previous dentist? _____

What is the most important thing to you about your future smile and dental health? _____

What is the most important thing to you about your dental visit today? _____

MEDICAL HISTORY

Please check any of the following problems/conditions that apply to you:

	YES		YES		YES		YES
AIDS	☐	Dizziness	☐	HIV Positive	☐	Scarlet Fever	☐
Allergies (Seasonal)	☐	Drug Addiction	☐	HPV (Human Papilloma Virus)	☐	Seizures	☐
Anemia	☐	Emphysema	☐	Jaundice	☐	Sinus Problems	☐
Angina (Chest pain)	☐	Epilepsy	☐	Jaw Joint Pain	☐	Sleep Apnea	☐
Arthritis	☐	Excessive Bleeding	☐	Kidney Disease	☐	Stomach Problems	☐
Artificial Heart Valve	☐	Fainting	☐	Liver Disease	☐	Stroke	☐
Artificial Joints	☐	Glaucoma	☐	Low Blood Pressure	☐	Thyroid Disease	☐
Asthma	☐	Heart Conditions	☐	Mitral Valve Prolapse	☐	Tuberculosis	☐
Blood Disease	☐	Heart Lesions (Congenital)	☐	Nervousness/Depression	☐	Ulcers	☐
Bruise Easily	☐	Heart Murmur	☐	Pacemaker	☐	Venereal Diseases	☐
Cancer	☐	Heart Surgery	☐	Pregnant Currently	☐	Other _____	
Cervical Cancer	☐	Hepatitis A	☐	Radiation (head/neck)	☐		
Chemotherapy	☐	Hepatitis B	☐	Respiratory Problems	☐		
Cortisone Medication	☐	Hepatitis C	☐	Rheumatic Fever	☐		
Diabetes	☐	High Blood Pressure	☐	Rheumatism	☐		

Are you allergic or have you reacted adversely to any of the following medications?

	YES		YES		YES		YES
Aspirin	☐	Percodan	☐	Tetracycline	☐	Valium	☐
Darvon	☐	Latex	☐	Codeine	☐	Penicillin	☐
Nitrous Oxide	☐	Local Anesthetic	☐	Erythromycin	☐	Sulfa	☐

Other _____

Have you ever taken any the following medications?

	YES		YES
Actonel	☐	Zometa	☐
Aredia	☐	Boniva	☐
Fosamax	☐	Herbal Supplements	☐
Reclast	☐		

Are you under a physician's care? What for?

_____

What medications are you currently taking?

_____

Family Physician Phone Number

_____

Consent:

The undersigned herby authorizes Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I have read, understand and agree to the above terms and conditions.

_____

Electronic Signature of Responsible Party

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Notice of Privacy Practices Acknowledgement and Consent

The Notice of Privacy Practices tells you how we may use and share your health records.

We will use and share your health records:

- To treat you and to bill for the services we provide
- To run our business for our healthcare operations
- As required by law

All the ways we may use and share your health records are explained in more detail in the Notice of Privacy Practices.

You have the following rights with respect to your health records.

- You have the right to look at and receive a copy of your health records
- You have the right to receive a list of whom we have given your health records to
- You have the right to as for us to correct a mistake in your health records
- You have the right to ask that we not use or share your health records
- You have the right to ask us to change the way we contact you

All of these rights are explained in more details in the Notice of Privacy Practices.

I have received a copy and/or read Apple Tree Dental Center's Notice of Privacy Practices and consent to the use and sharing of my health records for treatment, payment, and operation purposes as described in the Notice of Privacy Practices.

_____

Electronic Signature of Responsible Party

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Financial Policy

Thank you for choosing our office as your healthcare provider. We are committed to providing you with the highest quality lifetime dental care, so that you may attain optimum oral health. The following statement of our financial policy, which we require that you read, agree to and sign prior to any treatment. Please note that payment of your bill is considered part of your treatment. Payment is due at the time service is provided. For your convenience our office accepts cash, personal checks, Mastercard, Visa, Discover and AMEX. Outside financing is available upon request and approval.

Please ask us if you would like more information about financing options.

It is your responsibility to bring in your most current insurance card with you to each office visit. You will be asked to present your insurance card and current driver's license/ state ID upon arrival. If you have changed carriers it is your responsibility to update us upon scheduling your appointment. We emphasize that our relationship is with you, not with your insurance company. Your insurance policy is between you, your employer and insurance company. Our office is not a party in that contract. We ask that you sign this form and/or any other necessary documents that may be require by your insurance company. This form instructs your insurance company to make payments directly to our office. We will cooperate fully with the regulations of your insurance company that may assist in the claim being paid. Our office will not, however, enter a dispute with your insurance company over any claim.

Insurance payments are usually received within 30-60 days from the filing date. If your insurance company has not made a payment within **two submission** attempts by our office, we will ask that you contact them regarding payment. You will be billed for the unpaid amount after our second attempt to receive payment from your insurance company. If payment is not received or your claim is denied for any reason out of our control, you are responsible for paying the full amount at that time.

Returned check fee of $25 per item per return is charged for all returned checks for any reason.

Missed appointments. We understand that on occasion last minute schedule changes are unavoidable. It is important for you to understand that when you make an appointment, you have engaged the services of at least three professionals. When a patient misses an appointment, they often think that the doctor has other patients to see. Typically, this is not true because we do not double book appointments in our practice. Therefore, appointments not cancelled within 24 hours and multiple cancelled or no show appointments will be, at our discretion, charged a $25 operatory fee.

Consent:

I have read, understand and agree to the above terms and conditions. I authorize my insurance company to pay my dental benefits directly to my dental office. The undersigned hereby authorizes the Doctor to take X-rays, study models, photos, or any other diagnostic aids deemed appropriate by the Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize the Doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I also understand that the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for services provided in this office for my dependents or myself is mine, due and payable at the time services are rendered. I further understand that finance, re-billing, collection charges and attorney fees will be added to any overdue balance.

_____

Electronic Signature of Responsible Party

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Agreement to Resolve Future Malpractice Claim by Binding Arbitration

This Agreement to Resolve Future Malpractice Claim by Binding Arbitration ("Agreement is entered by and between Apple Tree Dental Center and Patient"), and collectively Healthcare Provider and Patient are referred to herein after as the "Parties".

In the event of any dispute or controversy arising out of the diagnosis, treatment, or care of the Patient by the Healthcare Provider, the dispute or controversy shall be submitted to binding arbitration.

Within fifteen (15) days after a Party to this Agreement has given written notice to the other of demand for arbitration of said dispute or controversy, the Parties to the dispute or controversy shall each appoint an arbitrator and give notice of such appointment to the other. Within a reasonable time after such notices have been given the two (2) arbitrators so selected shall select a neutral arbitrator and give notice of the selection thereof to the Parties. The arbitrators shall hold a hearing within a reasonable time from the date of notice of selection of the neutral arbitrator.

Expenses of the arbitration shall be shared equally by the Parties to this Agreement.
The Patient, by signing this Agreement, also acknowledges that the Patient has been informed that:

1) Care, diagnosis, or treatment may be provided whether or not an existing patient signs the Agreement to arbitrate;
2) The Agreement may not even be submitted to the Patient for approval when the Patient's condition prevents the Patient from making a rational decision' whether or not to agree;
3) The decision whether or not to sign the Agreement is solely a matter for the Patient's determination without any influence;
4) The Agreement waives the Patient's right to a trial in court for any future malpractice claim the Patient may have against the Healthcare Provider;
5) The Patient must be furnished with two (2) copies of this Agreement upon request.

PATIENT'S RIGHT TO CANCEL AGREEMENT TO ARBITRATE

The Patient, or the Patient's spouse or the personal representative of the Patient's estate m the event of the Patient's death or incapacity, has the right to cancel this Agreement to arbitrate by notifying the Healthcare Provider in writing within thirty (30) days after the Patient's signing of the Agreement. The Patient, or the Patient's spouse or representative, as appropriate, may cancel this Agreement by merely writing "cancelled' on the face of one of the Patient's copies of the Agreement, signing the Patient's name under such word, and mailing, by certified mail, return receipt requested, din copy to the Healthcare Provider within the thirty (30) day period.
Filing of a medical claim in a court within the thirty (30) days provided for cancellation of the arbitration agreement by the Patient will cancel the Agreement without any further action by the Patient.

_____

Electronic Signature of Responsible Party