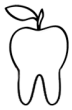
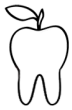


Apple Dental

726 E. Lamar Alexander Pkwy
Maryville, TN 37904
(865) 604-6227



Today's Date:_____

Name:_____

Date of Birth:_____ Soc. Sec. #:_____

Email Address: _____ Telephone #:_____

Address:_____

City:_____ State:_____ ZIP:_____

Guardian's Name (If under 18):_____ Guardian Phone #: _____

MEDICAL HISTORY

1. Have you been under a physician's care during the last two years?..... Yes No
2. Are you taking any medications? (perscription or over the counter drugs)..... Yes No
   If yes, please list:_____
3. Are you allergic to any drugs?..... Yes No
   If yes, please list:_____
4. Do you have a history of narcotic drug addiction or dependency?..... Yes No
   If yes, are you currently in treatment or taking medication for opioid addiction? Yes: _____ No: _____
5. **For children under 13**: Is the child up to date on all vaccinations/immunizations?..... Yes No
6. Have you ever bled excessively after an injury or tooth extraction?..... Yes No
7. Has there been any change in your general health in the last year?..... Yes No
8. Have you had unexplained weight loss, night sweats, or chronic cough?..... Yes No
9. Have you had **dental x-rays** in the last year?..... Yes No
10. Have you ever had an injury to your face or jaw?..... Yes No
11. Have you ever fainted in the dental office?..... Yes No
12. Do you use tobacco in any form?..... Yes No
    If yes, check all that apply: Chew:____ Dip:____ Cigarettes:____ Cigars:____ Pipe:____ Vape: ____
13. Have you ever had surgery for a tumor or growth on your mouth, face, or neck?..... Yes No
14. **WOMEN:** Are you pregnant now? (please answer "yes" if you are unsure)..... Yes No
    Do you anticipate becoming pregnant?:..... Yes No
    Are you past menopause?:..... Yes No
15. **Are you in good general health?**..... Yes No

DENTAL HISTORY

1. Do you have pain in or near your ears?..... Yes No
2. Do you have any unhealed injuries or inflamed areas in, or around your mouth?..... Yes No
3. Have you experienced any growth or sore spots in your mouth?..... Yes No
4. Have you ever had Novocaine anesthetic?..... Yes No
5. Any reactions or allergic symptoms from Novocaine?..... Yes No
6. Any difficult extractions in the past?..... Yes No
7. Any prolonged bleeding following extractions in the past?..... Yes No
8. Do you at the present time have any dental complaints?..... Yes No
   If yes, please summerize:_____
9. Do you clench your teeth during the night or day?..... Yes No
10. When was your last full mouth X-Ray taken?:_____ Where?:_____

HEALTH QUESTIONNAIRE

1. To the best of your knowledge, do you have or have you had any of the following conditions?
Circle all that apply

Heart Trouble (any kind)*	High or Low Blood Pressure	Steroid (Cortisone) Medication
Fen-Phen Heart Valve Damage**	Bleed Excessively	Parkinson's Disease
Mitral Valve Prolapse (MVP)*	Blood Disorder	Arthritis
Valve Defect/Surgery	Hemophilia	Anxiety/Depression/Schizophrenia
Heart Bypass	Anemia	Dry Mouth (Xerostomia)
Heart Pacemaker/Defibrillator	Take Blood Thinner / Aspirin	Anorexia / Bulimia
Enlarged or Congestive Heart	Sickle Cell Disease	Artificial Joint/Bone Replacement*
Rheumatic Fever*	Cancer	Diabetes
Angina	Emphysema / Chronic Bronchitis	Hypoglycemia
Heart Attack	Asthma	Ulcers
Endocarditis*	Seizure Disorder / Epilepsy	Tuberculosis
Spleen Removal	Kidney Dialysis	Thyroid Disease
Heart Murmur	Immune System Suppression	Sexually Transmitted Disease
Stroke	Systemic Lupus Erythematosus	Liver Disease / Hepatitis
Shunt	Multiple Sclerosis	Mononucleosis
Implant/Graft of Artery, Vein, Other	Transplanted Organ	HIV Positive / AIDS

2. Describe any other medical conditions you have that are not llisted above:_____

_____

_____

*If yes, we may require a letter from your physician stating he/she has examined you and that you may undergo dental treatment.

**Due to potential heart damage caused by Fen-Phen, the AMA guideline states all former Fen-phen users must have a physical before dental treatment.

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to the third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services on my behalf or my dependents.

Patient Signature:_____ Date:_____