

# Apple Valley Dental Group PLC

Harry M. Sartelle III DDS PC • Paul G. Byers DDS MS  
William Jeffrey, DDS



## PATIENT INFORMATION

DATE \_\_\_\_\_

NAME \_\_\_\_\_  MARRIED  SINGLE  MINOR  
LAST FIRST MI

ADDRESS \_\_\_\_\_  MALE  FEMALE

BIRTHDATE \_\_\_\_\_ AGE \_\_\_\_\_ TELEPHONE \_\_\_\_\_ / \_\_\_\_\_  
MO DAY YR HOME WORK

EMPLOYER \_\_\_\_\_

OCCUPATION \_\_\_\_\_

ADDRESS \_\_\_\_\_ S.S.# \_\_\_\_\_

CELL PHONE \_\_\_\_\_ EMAIL \_\_\_\_\_

DENTAL INSURANCE CO. \_\_\_\_\_ GROUP NO. \_\_\_\_\_

HAS ANY MEMBER OF YOUR FAMILY EVER BEEN TREATED IN OUR OFFICE?  YES  NO

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? \_\_\_\_\_

## PATIENT INFORMATION

SPOUSE/PARENT		CHILDREN	
NAME		NAME	AGE
NAME _____		1. _____	_____
ADDRESS _____		2. _____	_____
TELEPHONE _____		3. _____	_____
BIRTHDATE _____ S.S.# _____		4. _____	_____
EMPLOYER _____		5. _____	_____
OCCUPATION _____		6. _____	_____
DENTAL INSURANCE CO. _____			
GROUP# _____			

**PERSON RESPONSIBLE FOR ACCOUNT** CHECK ONE  Patient  Father/Husband  Mother/Wife  Guardian

**EMERGENCY CONTACT** NAME \_\_\_\_\_ TEL.# \_\_\_\_\_  
LAST FIRST MI

ADDRESS \_\_\_\_\_  
STREET CITY STATE ZIP

## MEDICAL HISTORY

MEDICAL DOCTOR'S NAME \_\_\_\_\_ PHONE NUMBER \_\_\_\_\_

YES  NO ARE YOU CURRENTLY UNDER A DOCTOR'S CARE? WHY? \_\_\_\_\_

YES  NO HAVE YOU BEEN HOSPITALIZED IN THE LAST TWO YEARS? WHY? \_\_\_\_\_

OVER

- YES  NO ARE YOU TAKING ANY PILLS, MEDICATIONS, AND/OR DRUGS? WHAT KIND?  
\_\_\_\_\_
- YES  NO DO YOU HAVE ANY ALLERGIES OR ARE YOU ALLERGIC TO ANY MEDICATIONS? WHAT KIND?  
\_\_\_\_\_
- YES  NO DO YOU TAKE ASPIRIN ON A DAILY BASIS? HOW MUCH?  
\_\_\_\_\_
- YES  NO DO YOU TAKE VITAMINS? WHAT KIND?  
\_\_\_\_\_

DOCTOR'S NOTES:

**PLEASE CIRCLE IF YOU HAVE ANY OF THE FOLLOWING:**

- |                         |                        |                        |                    |
|-------------------------|------------------------|------------------------|--------------------|
| Heart Trouble           | Tuberculosis           | Shortness of Breath    | Hypoglycemia       |
| High Blood Pressure     | Liver Disease          | Fainting or Dizziness  | Psychiatric Care   |
| Low Blood Pressure      | Hepatitis A (infect)   | Stroke                 | Drug Addiction     |
| Mitral Valve Prolapse   | Hepatitis B (serum)    | Diabetes               | Alcoholism         |
| Heart Murmur            | Hepatitis C            | Artificial Joints/Hips | Blood Transfusion  |
| Rheumatic Fever         | Cancer                 | Kidney Trouble         | Hemophilia         |
| Congenital Heart Lesion | Parathyroid Disease    | Ulcers                 | AIDS/HIV Positive  |
| Artificial Heart Valve  | Chemotherapy/Radiation | Allergies              | Veneral Disease    |
| Heart Pacemaker         | Arthritis/Gout         | Asthma                 | Fever Blisters     |
| Heart Surgery           | Rheumatism             | Hay Fever              | Herpes             |
| Blood Disease           | Pain in Jaw Joints     | Sinus Trouble          | Pregnancy          |
| Anemia                  | Epilepsy/Seizures      | Emphysema              | Smoking            |
| Chest Pain              | Nervousness            | Lung Disease           | Excessive Bleeding |
| Birth Control Medicine  | Bleeding Disorder      |                        |                    |

- YES  NO HAVE YOU EVER HAD ANY OTHER SERIOUS ILLNESS NOT CIRCLED?  
DESCRIBE IN DETAIL \_\_\_\_\_
- YES  NO DO YOU WISH TO TALK TO THE DOCTOR PRIVATELY ABOUT ANY PROBLEMS?

**METHOD OF PAYMENT**

- PAYMENT IN FULL AT EACH APPOINTMENT  
 PAYMENT OF NON-INSURANCE PORTION AT EACH APPOINTMENT

FINANCE CHARGE: If I do not pay the entire New Balance within 60 days of the monthly billing date, a FINANCE CHARGE will be added to the account for the current monthly billing cycle. The FINANCE CHARGE will be a periodic rate of 1.5% per month (or a minimum charge of \$3.00 for a balance under \$200.00) which is an ANNUAL PERCENTAGE RATE of 18% applied to the last month's balance. In the case of default of payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection on this account.

**AUTHORIZATION**

I hereby authorize payment directly to Apple Valley Dental Group of the group benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize Harry M. Sartelle III DDS or Paul G. Byers DDS MS or William Jeffrey, DDS to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary to proper dental care. The information on this page and the medical history are correct to the best of my knowledge.

X \_\_\_\_\_ DATE \_\_\_\_\_  
 Adult Patient  Father/Husband  Mother/Wife  Guardian

**MEDICAL HISTORY UPDATE**

I have read my medical history dated \_\_\_\_\_ and confirmed that it states past and present medical conditions. \_\_\_\_\_  
Signature Date

I have read my medical history dated \_\_\_\_\_ and confirmed that it states past and present medical conditions. \_\_\_\_\_  
Signature Date

I have read my medical history dated \_\_\_\_\_ and confirmed that it states past and present medical conditions. \_\_\_\_\_  
Signature Date