James T. Thedford D.D.S.
17323 ! 35 N. ste. 112
Schertz, Tx 78154
210-654-8500 Office
210-654-8505 fax

Welcome To Apple Dental!

Patient Name:_____ Date: _____

ReasonForToday'Visit_____

_____

___Toothache ?Pain ___Removal of Wisdom Teeth____Bridge/Partial/Denture ____Gum Bleeding/Pain___Chipped or cracked tooth____ Braces/Invisalign ____Implants

What do you want to accomplish from the visit Today?

_____

_____

_____

Is there anything you would like to discuss with the doctor today?

_____

_____

_____

How did you hear about our office?

_____Drive by/walked by
_____Insurance Company
_____ Transfer from another office
_____Patient Referral
_____Online search
_____Staff
_____ Other
_____ Mailer
_____Referral (if yes, from who?)_____

What are the best days to schedule your appointment ? _____
What are the best times to schedule your appointments?_____
Best Contact Numbers : (____)_____ or (_____)_____
Can you accept texts messages Yes or No
Email address: _____
Interested in 3rd party Financing Yes or No

Patient Information (Confidential)

Patient Name:_____ Date:_____

Address:_____City_____State_____Zip_____

Soc Sec:_____Birthday:_____Email:_____

Home:_____Cell:_____OtherPhone:_____

_____Minor_____Single_____Married_____Divorced_____Widowed_____Separate

Patient's Employer_____Wk Phone:_____

Business address_____City_____State_____Zip_____

Spouse Name_____Employer_____wk Phone_____

Person to contact in case of an emergency_____Home_____

Responsible Party

Name of Person Responsible for this Account_____Phone#_____

Relationship to Patient_____Driver's License#_____Birthday_____

Soc Sec:_____Employer_____Wk Phone_____

Is this Patient Currently a patient in our office ____Yes _____No If so, What office_____

Insurance Information

Name of Insured _____Relationship to Patient_____

Birthday_____Soc Sec_____Insured Id #_____

Name of Employer_____Wk Phone_____

Employer Address_____City_____State_____Zip_____

DO YOU HAVE ANY ADDITIONAL INSURNACE? ___Yes ____No If Yes, Complete the Following

Name of Insured _____Relationship to Patient_____

Birthday_____Soc Sec_____Insured Id #_____

Name of Employer_____Wk Phone_____

Employer Address_____City_____State_____Zip_____

_____ _____

SIGNATURE OF PATIENT OR PARENT IF MINOR DATE PATEINT NUMBER

ADA. American Dental Association
www.ada.org

Medical Alert:	Condition:	Premedication:	Allergies:	Anesthesia:	Date:

HEALTH HISTORY FORM

Name: _____ Home Phone: ( ) _____ Business Phone: ( ) _____
LAST FIRST MIDDLE

Address: _____ City: _____ State: _____ Zip Code: _____
P.O. BOX or Mailing Address

Occupation: _____ Height: _____ Weight: _____ Date of Birth: _____ Sex: M ❑ F ❑

SS#: _____ Emergency Contact: _____ Relationship: _____ Phone: ( ) _____

If you are completing this form for another person, what is your relationship to that person?
NAME RELATIONSHIP

For the following questions, please (X) whichever applies, your answers are for our records only and will be kept confidential in accordance with applicable laws. Please note that during your initial visit you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

DENTAL INFORMATION

	Yes	No	Don't Know
Do your gums bleed when you brush?	❑	❑	❑
Have you ever had orthodontic (braces) treatment?	❑	❑	❑
Are your teeth sensitive to cold, hot, sweets or pressure?	❑	❑	❑
Do you have earaches or neck pains?	❑	❑	❑
Have you had any periodontal (gum) treatments?	❑	❑	❑
Do you wear removable dental appliances?	❑	❑	❑
Have you had a serious/difficult problem associated with any previous dental treatment?	❑	❑	❑

If yes, explain: _____

How would you describe your current dental problem? _____

Date of your last dental exam: _____

Date of last dental x-rays: _____

What was done at that time? _____

How do you feel about the appearance of your teeth? _____

MEDICAL INFORMATION

	Yes	No	Don't Know
If you answer yes to any of the 3 items below, please stop and return this form to the receptionist.			
Have you had any of the following diseases or problems?			
Active Tuberculosis	❑	❑	❑
Persistent cough greater than a 3 week duration	❑	❑	❑
Cough that produces blood	❑	❑	❑
Are you in good health?	❑	❑	❑
Has there been any change in your general health within the past year?	❑	❑	❑
Are you now under the care of a physician?	❑	❑	❑

If yes, what is/are the condition(s) being treated? _____

Date of last physical examination: _____

Physician: _____
NAME PHONE

ADDRESS CITY/STATE ZIP

NAME PHONE

ADDRESS CITY/STATE ZIP

Have you had any serious illness, operation, or been hospitalized in the past 5 years?	❑	❑	❑

If yes, what was the illness or problem? _____

	Yes	No	Don't Know
Are you taking or have you recently taken any medicine(s) including non-prescription medicine?	❑	❑	❑

If yes, what medicine(s) are you taking?

Prescribed: _____

Over the counter: _____

Vitamins, natural or herbal preparations and/or diet supplements: _____

Are you taking, or have you taken, any diet drugs such Pondimin (fenfluramine), Redux (dexphenfluramine) or phen-fen (fenfluramine-phentermine combination)?	❑	❑	❑
Do you drink alcoholic beverages?	❑	❑	❑

If yes, how much alcohol did you drink in the last 24 hours?

In the past week? _____

Are you alcohol and/or drug dependent?	❑	❑	❑

If yes, have you received treatment? (circle one) Yes / No

Do you use drugs or other substances for recreational purposes?	❑	❑	❑

If yes, please list: _____

Frequency of use (daily, weekly, etc.): _____

Number of years of recreational drug use: _____

Do you use tobacco (smoking, snuff, chew)?	❑	❑	❑

If yes, how interested are you in stopping?
(circle one) Very / Somewhat / Not interested

Do you wear contact lenses?	❑	❑	❑

PLEASE COMPLETE BOTH SIDES

Are you allergic to or have you had a reaction to?	Yes	No	Don't Know
Local anesthetics	❑	❑	❑
Aspirin	❑	❑	❑
Penicillin or other antibiotics	❑	❑	❑
Barbiturates, sedatives, or sleeping pills	❑	❑	❑
Sulfa drugs	❑	❑	❑
Codeine or other narcotics	❑	❑	❑
Latex	❑	❑	❑
Iodine	❑	❑	❑
Hay fever/seasonal	❑	❑	❑
Animals	❑	❑	❑
Food (specify) _____	❑	❑	❑
Other (specify) _____	❑	❑	❑
Metals (specify) _____	❑	❑	❑

To yes responses, specify type of reaction. _____

_____

_____

_____

	Yes	No	Don't Know
Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?	❑	❑	❑
If yes, when was this operation done? _____			
If you answered yes to the above question, have you had any complications or difficulties with your prosthetic joint? _____			
Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?	❑	❑	❑
If yes, what antibiotic and dose? _____			
Name of physician or dentist*: _____			
Phone: _____			

WOMEN ONLY

Are you or could you be pregnant?	❑	❑	❑
Nursing?	❑	❑	❑
Taking birth control pills or hormonal replacement?	❑	❑	❑

Please (X) a response to indicate if you have or have not had any of the following diseases or problems.

	Yes	No	Don't Know
Abnormal bleeding	❑	❑	❑
AIDS or HIV infection	❑	❑	❑
Anemia	❑	❑	❑
Arthritis	❑	❑	❑
Rheumatoid arthritis	❑	❑	❑
Asthma	❑	❑	❑
Blood transfusion. If yes, date: _____	❑	❑	❑
Cancer/Chemotherapy/Radiation Treatment	❑	❑	❑
Cardiovascular disease. If yes, specify below:	❑	❑	❑
____ Angina ____ Heart murmur			
____ Arteriosclerosis ____ High blood pressure			
____ Artificial heart valves ____ Low blood pressure			
____ Congenital heart defects ____ Mitral valve prolapse			
____ Congestive heart failure ____ Pacemaker			
____ Coronary artery disease ____ Rheumatic heart			
____ Damaged heart valves disease/Rheumatic fever			
____ Heart attack			
Chest pain upon exertion	❑	❑	❑
Chronic pain	❑	❑	❑
Disease, drug, or radiation-induced immunosurpression	❑	❑	❑
Diabetes. If yes, specify below:	❑	❑	❑
____ Type I (Insulin dependent) ____ Type II			
Dry Mouth	❑	❑	❑
Eating disorder. If yes, specify: _____	❑	❑	❑
Epilepsy	❑	❑	❑
Fainting spells or seizures	❑	❑	❑
Gastrointestinal disease	❑	❑	❑
G.E. Reflux/persistent heartburn	❑	❑	❑
Glaucoma	❑	❑	❑

	Yes	No	Don't Know
Hemophilia	❑	❑	❑
Hepatitis, jaundice or liver disease	❑	❑	❑
Recurrent Infections	❑	❑	❑
If yes, indicate type of infection: _____			
Kidney problems	❑	❑	❑
Mental health disorders. If yes, specify: _____	❑	❑	❑
Malnutrition	❑	❑	❑
Night sweats	❑	❑	❑
Neurological disorders. If yes, specify: _____	❑	❑	❑
Osteoporosis	❑	❑	❑
Persistent swollen glands in neck			
Respiratory problems. If yes, specify below:	❑	❑	❑
____ Emphysema ____ Bronchitis, etc.			
Severe headaches/migraines	❑	❑	❑
Severe or rapid weight loss	❑	❑	❑
Sexually transmitted disease	❑	❑	❑
Sinus trouble	❑	❑	❑
Sleep disorder	❑	❑	❑
Sores or ulcers in the mouth	❑	❑	❑
Stroke	❑	❑	❑
Systemic lupus erythematosus	❑	❑	❑
Tuberculosis	❑	❑	❑
Thyroid problems	❑	❑	❑
Ulcers	❑	❑	❑
Excessive urination	❑	❑	❑
Do you have any disease, condition, or problem not listed above that you think I should know about?	❑	❑	❑
Please explain: _____			

NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

SIGNATURE OF PATIENT/LEGAL GUARDIAN _____ DATE _____

FOR COMPLETION BY DENTIST

Comments on patient interview concerning health history: _____

_____

Significant findings from questionnaire or oral interview: _____

_____

Dental management considerations: _____

Health History Update: On a regular basis the patient should be questioned about any medical history changes, date and comments notated, along with signature.

Date	Comments	Signature of patient and dentist
_____	_____	_____
_____	_____	_____

CONFIDENTIAL

CONSENT

Date _____ SS/HIC/Patient ID# _____

Patient Name _____ Date of Birth_____

Please read and initial the items checked below. Then read and sign the section at the bottom of form.

☐ **1. Work to be Done**

I understand that I am having the following work done: Fillings_____ Bridges_____ Crowns_____ Extractions _____
Impacted teeth removed_____ General Anesthesia_____ Root Canals_____ Other Exam, Xrays, Clea

(Initials_____

☐ **2. Drugs and Medications**

I understand that antibiotics and analgesics and other medications can cause allergic reactions causing redness and swelling of tissu
itching, vomiting, and/or anaphylactic shock (severe allergic reaction).

(Initials_____

☐ **3. Changes in Treatment Plan**

I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the t
were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my perm
the Dentist to make any/all changes and additions as necessary.

(Initials_____

☐ **4. Removal of Teeth**

Alternatives to removal have been explained to me (root canal therapy, crowns, and periodontal surgery, etc.) and I authorize the Dentist t
the following teeth _____ and any others necessary for reasons in paragraph #3. I understand removing teeth
always remove all the infection, if present, and it may be necessary to have further treatment. I understand the risks involved in having teeth
some of which are pain, swelling, spread of infection, dry socket, loss of feeling in my teeth, lips, tongue and surrounding tissue (Paresthesia)
last for an indefinite period of time (days or months) or fractured jaw. I understand I may need further treatment by a specialist or even hospi
if complications arise during or following treatment, the cost of which is my responsibility.

(Initials_____

☐ **5. Crown, Bridges and Caps**

I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that
wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent cr
delivered. I realize the final opportunity to make changes in my new crown, bridge, or cap (including shape, fit, size, and color) will b
cementation.

(Initials_____

☐ **6. Dentures, Complete or Partial**

I realize that full or partial dentures are artificial, constructed of plastic, metal, and/or porcelain. The problems of wearing these appliar
been explained to me, including looseness, soreness, and possible breakage. I realize the final opportunity to make changes in my new
(including shape, fit, size, placement, and color) will be the "teeth in wax" try-in visit. I understand that most dentures require relining appro
three to twelve months after initial placement. The cost for this procedure is not included in the initial denture fee.

(Initials_____

☐ **7. Endodontic Treatment (Root Canal)**

I realize there is no guarantee that root canal treatment will save my tooth, and that complications can occur from the treatment.
occasionally metal objects are cemented in the tooth or extend through the root, which does not necessarily affect the success of the tre
understand that occasionally additional surgical procedures may be necessary following root canal treatment (apicoectomy).

(Initials_____

☐ **8. Periodontal Loss (Tissue & Bone)**

I understand that I have a serious condition, causing gum and bone infection or loss and that it can lead to the loss of my teeth. A
treatment plans have been explained to me, including gum surgery, replacements and/or extractions. I understand that undertaking a
procedures may have a future adverse effect on my periodontal condition.

(Initials_____

I understand that dentistry is not an exact science and that, therefore, reputable practitioners cannot guarantee results. I acknowledg
guarantee or assurance has been made to me by anyone regarding the dental treatment that I have requested and authorized for my self or
child. I have had full opportunity to discuss and ask questions regarding the dental treatment, and all questions have been answered to my sa

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____
Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

****You May Refuse to Sign This Acknowledgement****

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
{Please Print Name}

_____
{Signature}

_____
{Date}

Authorization to Release Information

Purpose: This form is used to obtain authorization to release information regarding yourself covered under the Privacy Act to people other than yourself.

I, _____, authorize the following person(s) to have access to information covered under the Privacy Practice regarding myself.

_____ {Please Print Name}	_____ Relationship
_____ {Please Print Name}	_____ Relationship
_____ {Please Print Name}	_____ Relationship

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____

Apple Dental

Broken appointment policy

Reserved appointment time in any dental office is limited and valuable. It is extremely important that all patients honor their reserved dental appointments. Failure to do so deprives our other patients from receiving needed dental care in a timely fashion.

So that the dentist, our staff, and our patients will not be penalized by those who fail to keep scheduled appointments, our office policy stipulates that failure to give sufficient warning to keep a scheduled appointment (24 hours advance notification), will result in a $50.00 fee being charged. That charge, which is in accordance with out dental office's broken policy for all of our patients, is to be paid within 30 days to prevent collection procedures. The patient/parent/legal guardian is responsible for the payment of the charge.

Please feel free to discuss this and other policies with our staff. Do not hesitate to call our office if you have any questions.

Patient Name	Signature	Date

Apple Dental

Financial Policy

We are privileged you have chosen us as your dental care provider. We are committed to providing you and your family with quality patient care. The following is a statement of our Financial Policy, which you need to understand prior to treatment. If you have any questions, please feel free to ask.

Full payment is due at the time of service. We accept cash, checks, and most major credit cards. There will be a $35.00 fee on all returned checks. Also, we reserve the right to charge for appointments canceled or broken without 24 hours advance notice.

Regarding Insurance

Your insurance policy is a contract between you and your insurance company. We have no control over their decisions and the amount they decide to pay. However, as a courtesy to our patients, we will file your primary insurance claims for you. Before treatment, we will verify your coverage and calculate your deductible and copayments as accurately as possible. Please understand that all treatment plans given are only an estimate based on the information your insurance company provides. All deductibles and copayments are due the day the treatment is rendered. Please be aware that your insurance company does not guarantee payment over the phone. We will not know the exact amount they will pay until they respond to the claim.

REGARDLESS OF WHAT YOUR INSURANCE COMPANY PAYS, YOU REMAIN FULLY RESPONSIBLE FOR PAYMENT OF YOUR BILL.

Once a payment is received on your claim, we will send you a bill of any remaining balance on your account.

At our discretion, any unpaid balance after 90 days will be sent to collections at which the patient is responsible for any fees associated with the collection for the balance.

I have read and understand the above Financial Policy. By signing below, I acknowledge responsibility and agree to the terms above.

Patient Name	Signature	Date