APEX DENTAL CARE

Dr. I. Gary Shmurak, DMD
1600 Horizon Drive, Suite 119, Chalfont, PA 18914
tel: **215-996-9968** • fax: 215-996-9971

WELCOME

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

PATIENT INFORMATION

LAST NAME _____ FIRST NAME _____

SOC. SEC. # _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____ HOME PHONE _____

CELL PHONE _____ EMAIL _____

SEX ☐M ☐F AGE _____ BIRTH DATE ____/_____/_____ ☐SINGLE ☐MARRIED ☐WIDOWED ☐SEPARATED ☐DIVORCED

PATIENT EMPLOYED BY _____ OCCUPATION _____

BUSINESS ADDRESS _____

BUSINESS PHONE _____ BUSINESS EMAIL _____

NOTIFY IN CASE OF EMERGENCY _____ HOME PHONE _____

CELL PHONE _____ BUSINESS PHONE _____ EMAIL _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

PRIMARY INSURANCE

PERSON RESPONSIBLE FOR ACCOUNT

LAST NAME _____ FIRST NAME _____

RELATION TO PATIENT _____ BIRTH DATE ____/_____/_____ SOC. SEC. # _____

ADDRESS (if different from patient) _____

CITY _____ STATE _____ ZIP _____ HOME PHONE _____

CELL PHONE _____ EMAIL _____

PERSON RESPONSIBLE EMPLOYED BY _____ OCCUPATION _____

BUSINESS ADDRESS _____

BUSINESS PHONE _____ BUSINESS EMAIL _____

INSURANCE COMPANY _____ PHONE _____

INSURANCE EMAIL _____ CONTRACT# _____ GROUP#_____ SUBSCRIBER# _____

NAME OF OTHER DEPENDENTS UNDER THIS PLAN _____

ADDITIONAL INSURANCE

IS PATIENT COVERED BY ADDITIONAL INSURANCE? ☐YES ☐NO

SUBSCRIBER NAME _____ RELATION TO PATIENT _____

BIRTH DATE ____/_____/_____ SOC. SEC. # _____

ADDRESS (if different from patient) _____

CITY _____ STATE _____ ZIP _____ HOME PHONE _____

CELL PHONE _____ EMAIL _____

SUBSCRIBER EMPLOYED BY _____

BUSINESS PHONE _____ BUSINESS EMAIL _____

INSURANCE COMPANY _____ PHONE _____

INSURANCE EMAIL _____ CONTRACT# _____ GROUP#_____ SUBSCRIBER# _____

NAME OF OTHER DEPENDENTS UNDER THIS PLAN _____

APEX DENTAL CARE

Dr. I. Gary Shmurak, DMD
1600 Horizon Drive, Suite 119, Chalfont, PA 18914
tel: 215-996-9968 • fax: 215-996-9971

DENTAL HISTORY

WHAT WOULD YOU LIKE US TO DO TODAY?_____ ARE YOU IN DENTAL DISCOMFORT TODAY? _____
FORMER DENTIST _____ DENTIST'S PHONE _____
ADDRESS _____
DATE OF LAST DENTAL CARE ____/_____/_____ DATE OF LAST X-RAYS ____/_____/_____
CHECK YES OR NO IF YOU HAVE HAD PROBLEMS WITH ANY OF THE FOLLOWING:

☐Y ☐N BAD BREATH ☐Y ☐N SENSITIVITY WHEN BITING ☐Y ☐N PERIODONTAL TREATMENT ☐Y ☐N LOOSE TEETH OR BROKEN FILLINGS
☐Y ☐N BLEEDING GUMS ☐Y ☐N SENSITIVITY TO COLD ☐Y ☐N SORES/GROWTHS IN MOUTH ☐Y ☐N GRINDING OR CLENCHING TEETH
☐Y ☐N SENSITIVITY TO HOT ☐Y ☐N SENSITIVITY TO SWEETS ☐Y ☐N CLICKING/POPPING JAW ☐Y ☐N FOOD COLLECTION BETWEEN TEETH

HOW OFTEN DO YOU BRUSH? _____ FLOSS? _____
HOW DO YOU FEEL ABOUT THE APPEARANCE OF YOUR TEETH? _____
HAVE YOU EVER EXPERIENCED AN ADVERSE REACTION DURING OR IN CONJUNCTION WITH A MEDICAL OR DENTAL PROCEDURE? ☐Y ☐N
OTHER INFORMATION ABOUT YOUR DENTAL HEALTH OR PREVIOUS TREATMENT _____

MEDICAL HISTORY

PHYSICIAN'S NAME_____ PHONE _____
DATE OF LAST VISIT ____/_____/_____ HAVE YOU HAD ANY SERIOUS ILLNESSES OR OPERATIONS? ☐Y ☐N
IF YES, DESCRIBE _____
ARE YOU CURRENTLY UNDER PHYSICIAN CARE? ☐Y ☐N IF YES, DESCRIBE _____
HAVE YOU EVER HAD A BLOOD TRANSFUSION? ☐Y ☐N IF YES, GIVE APPROXIMATE DATES _____
HAVE YOU EVER TAKEN FEN-PHEN/REDUX? ☐Y ☐N
HAVE YOU EVER USED A BISPHOSPHONATE MEDICATION? Brand names include Fosamax, Actonel, Atelvia, Didronel and Boniva. ☐Y ☐N
WOMEN: ARE YOU PREGNANT? ☐Y ☐N NURSING? ☐Y ☐N TAKING BIRTH CONTROL PILLS? ☐Y ☐N
CHECK YES OR NO IF YOU HAVE HAD PROBLEMS WITH ANY OF THE FOLLOWING:

☐Y ☐N AIDS/HIV POSITIVE
☐Y ☐N ANAPHYLAXIS
☐Y ☐N ANEMIA
☐Y ☐N ARTHRITIS, RHEUMATISM
☐Y ☐N ARTIFICIAL HEART VALVES
☐Y ☐N ARTIFICIAL JOINTS
☐Y ☐N ASTHMA
☐Y ☐N ATOPIC (Allergy prone)
☐Y ☐N BACK PROBLEMS
☐Y ☐N BLOOD DISEASE
☐Y ☐N CANCER
☐Y ☐N CHEMICAL DEPENDENCY
☐Y ☐N CHEMOTHERAPY
☐Y ☐N CIRCULATORY PROBLEMS
☐Y ☐N CORTISONE TREATMENTS
☐Y ☐N COUGH, PERSISTENT
☐Y ☐N COUGH UP BLOOD
☐Y ☐N DIABETES
☐Y ☐N EPILEPSY
☐Y ☐N FAINTING
☐Y ☐N FOOD ALLERGIES
☐Y ☐N GLAUCOMA
☐Y ☐N HEADACHES
☐Y ☐N HEART MURMUR
☐Y ☐N HEART PROBLEMS:
DESCRIBE _____
☐Y ☐N HEMOPHILIA/Abnormal bleeding
☐Y ☐N HERPES
☐Y ☐N HEPATITIS
☐Y ☐N HIGH BLOOD PRESSURE
☐Y ☐N JAW PAIN
☐Y ☐N KIDNEY DISEASE/MALFUNCTION
☐Y ☐N LIVER DISEASE
☐Y ☐N MATERIAL ALLERGIES
(☐Latex, ☐Wool, ☐Metal, ☐Chemicals)
☐Y ☐N MITRAL VALVE PROLAPSE
☐Y ☐N NERVOUS PROBLEMS
☐Y ☐N PACEMAKER/HEART SURGERY
☐Y ☐N PSYCHIATRIC CARE
☐Y ☐N RAPID WEIGHT GAIN OR LOSS
☐Y ☐N RADIATION TREATMENT
☐Y ☐N RESPIRATORY DISEASE
☐Y ☐N RHEUMATIC/SCARLET FEVER
☐Y ☐N SHINGLES
☐Y ☐N SHORTNESS OF BREATH
☐Y ☐N SKIN RASH
☐Y ☐N SPINA BIFIDA
☐Y ☐N STROKE
☐Y ☐N SURGICAL IMPLANT
☐Y ☐N SWELLING OF FEET OR ANKLES
☐Y ☐N THYROID DISEASE/MALFUNCTION
☐Y ☐N TOBACCO HABIT
☐Y ☐N TONSILLITIS
☐Y ☐N TUBERCULOSIS
☐Y ☐N ULCER/COLITIS
☐Y ☐N VENEREAL DISEASE

IS PATIENT CURRENTLY TAKING ANY MEDICATIONS? IF YES, LIST ALL: _____
DOES PATIENT HAVE DRUG ALLERGIES? IF YES, LIST ALL: _____

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.
I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered.
I authorize the use of this signature on all insurance submissions.
I authorize the dentist to release all information necessary to secure the payment of benefits.
I understand that I am financially responsible for all charges whether or not paid by insurance.

PATIENT NAME _____ DATE ____/_____/_____

Payment is due in full at time of treatment, unless prior arrangements have been approved.

CLEAR FORM • www.apexdent.com • EMAIL FORM SAVE FORM PRINT