**APPLECREEK DENTAL**
**Clifford O. Sorensen D.D.S.**
**120 S. State Street Suite C. Clearfield, UT 84015**
**801-773-2252**
**applecreekdental.com**

# REGISTRATION & HEALTH HISTORY

**PATIENT INFORMATION**

Patient Name: _____ _____ Sex: M F Birth Date: _____ Age: _____

Social Security #:_____ If Patient is a Minor, give Parent's or Guardian's name: _____ Date: _____

Whom may we thank for referring you to our office: _____ Patient's Cell phone#_____

**RESPONSIBLE PARTY INFORMATION**

Name: _____ Marital Status: _____ Relation To Patient: _____

Residence Street: _____ Apt. #_____ City: _____ State: _____ Zip_____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Social Security #:_____ Birth Date: _____ Drivers License#:_____ State_____

Employer: _____ Employer Address: _____ ____Occupation: _____

Patient's E Mail: _____ Responsible Party E-mail:_____

**EMERGENCY CONTACT INFORMATION – RELATIVE NOT LIVING WITH YOU**

Name: _____ Relationship: _____ Address: _____

Home Phone #:_____ Cell Phone: _____ Work Phone: _____

**DENTAL INSURANCE INFORMATION (PRIMARY)**

Insured's Name: _____

Insurance Company: _____

Insurance Company Phone #:_____

ID#_____ Group #_____

Insured's SS#:_____Birth Date: _____

**DENTAL INSURANCE INFORMATION (SECONDARY)**

Insured's Name: _____

Insurance Company: _____

Insurance Company Phone #:_____

ID# _____ Group #_____

Insured's SS#:_____Birth Date: _____

**DENTAL HISTORY**

Reason for today's visit: _____Date of last dental visit: _____

Prior Dentist Name:_____ _____ City: _____

Describe any dental concerns or problems:

_____

_____

Check any of the boxes that apply to you:

- O Previous Orthodontic treatment
- O Gums bleeding when brush or floss
- O Previous Periodontal Treatment (Deep Cleanings)
- O Loose or Missing Teeth
- O Smoke/ use tobacco
- O Grind teeth
- O Complications following dental work
- O Dry Mouth

What is the average # of carbonated beverages consumed in a week: _____
Teeth Sensitive: O Hot O Cold O Biting O Sweets O Not Sensitive
Are you interested in learning about different ways to improve your smile? O Yes O No

**MEDICAL HISTORY**

Patient Name: _____ _____ Sex: M F Birth Date: _____ Age: _____

**Any changes in your general health, or hospitalized in the last year?** Describe: _____

Are you under a physicians care now? If so, reason: _____

List current medications: _____

Name of Physician: _____ Physician's Phone #:_____

If you have ever had any of the following - Please check those that apply:

- O Currently Pregnant Due Date _____
- O Arthritis
- O Artificial Joints
- O Cancer
- O Endocarditis
- O Glaucoma
- O Heart-Birth Defects
- O HIV/AIDS
- O Medications (Many)
- O Nervous Disorders
- O Other Conditions
- O Radiation Treatment
- O Sinus Problems
- O Tuberculosis
- O Codeine Allergy
- O Epilepsy
- O Head Injuries
- O Hepatitis / Type _____
- O Kidney /Liver Disease
- O Mental Disorders
- O Osteoporosis Meds
- O Penicillin Allergy
- O Respiratory Problems
- O Stroke
- O Ulcers
- O Blood Problems / Anemia
- O Diabetes / Type _____
- O Epinephrine Problems
- O Heart Issues
- O High Blood Pressure
- O Latex Allergies
- O Other Allergies
- O Metal Allergies
- O Rheumatic Fever
- O Sulfa Allergy
- O Pre-Med Needed

**Medical Conditions Notes:**

**APPLE CREEK DENTAL OFFICE POLICIES**

I understand that payment in full is due at the time of service, and that the office policy does not accept partial payments. I consent and agree to be financially responsible for all fees not paid by insurance(s), as well as my portion at the time of service for myself and any of my dependents. I authorize the release of all necessary information to the insurance carrier(s) and their representatives as well as payment of benefits to the provider. If payment is not received by the due date on the statement, my account will receive a 1.8% finance charge per month, 21.6APR, and late fees will be charged. I agree to pay an additional amount representing 33.33% of the principal balance if my account is referred to a collection agency or attorney for collections. In recognition of the costs associated with collection processing.

I acknowledge that I have received and reviewed the Notice of Privacy Practices policy. I understand that I can access a copy of the policy at Apple Creek Dental or online at applecreekdental.com.

In the event that I miss or cancel an appointment(s) without 48 hours notice, I understand that there may be a broken appointment fee applied to my account.

**Cell Phone / E-mail Consent:**
I authorize Apple Creek Dental to transmit patient information relating to my treatment, health, or payment by e-mail, cell phone, or other electronic means, without encryption or special security precautions to me or someone I designate, or to other health care providers, health plans, insurance, and others involved in my treatment.

**Name: _____ Cell Phone #: _____**

**Name: _____ E-Mail Address: _____**

I acknowledge that I have read and do understand and agree to the conditions of this office policy, that the information is accurate and true to the best of my knowledge. I have read the above conditions of treatment and payment and agree to their content.

**Name(Print): _____ Signature: _____ Date: _____**

**WE APPRECIATE OUR PATIENTS – THANK YOU FOR COMING TO SEE DR. SORENSEN!!!**