APPLE DENTAL CENTER
(856) 875-5598
600 CROSS KEYS ROAD SUITE 100
SICKLERVILLE, NJ 08081

PATIENT GIVING CONSENT

Name: _____
Address: _____
Telephone: _____ Email: _____

By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operation.

Model Release: I hereby give permission to Apple Dental Center to use my photo/video for media, advertising, and any other lawful purpose.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to Apple Dental Center. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, received a copy of this office's Consent form and Notice of Privacy Practices.

Print Name: _____

Signature: _____

Date: _____

For Children Only

Personal Representative's Name: _____

Relationship to patient: _____

APPLE DENTAL CENTER

Cross Keys Medical & Dental Center – 600 Berlin-Cross Keys Rd – Suite 100 – Sicklerville, NJ 08081
PHONE: (856) 875 – 5598 – FAX: (856) 875 – 4501

Getting to know you:

Name:_____

Cell Phone:_____ **Home Phone:**_____

Email Address:_____

What dental concern do you have today:_____

Would you like a free smile/cosmetic analysis?_____

Would you like a free analysis to remove wrinkles and enhance lips with dermal fillers?_____

Occupation:_____

Referred By:

___Yellow Pages Gloucester County

___Yellow Pages Camden County

___Yellow Book

___Building

___Insurance Listing – Name of Insurance_____

___Friend/Family Member – Name_____

___Other-If so explain:_____

Name of Physician/Specialist:_____

Telephone Number:_____

Previous Dentist/Dental Office:_____

MAHESH U. PATEL, D.D.S.

NAME LAST	FIRST	MI	BIRTH DATE MO DAY YR	SOCIAL SECURITY NO. - -	SEX M O F O
STREET	DEVELOPMENT		PHONE NO. (HOME)		
CITY	STATE	ZIP	PHONE NO. (WORK)		
			PHONE NO. (CELL)		

MEDICAL - HISTORY
EACH QUESTION MUST BE ANSWERED

	CHECK ONE YES	NO
1. HAVE YOU BEEN A PATIENT IN A HOSPITAL DURING THE PAST YEAR?	O	O
2. HAVE YOU BEEN UNDER THE CARE OF A PHYSICIAN DURING THE PAST YEAR/	O	O
3. ARE YOU TAKING ANY MEDICATIONS?	O	O
4. HAS ANY ONE IN YOUR FAMILY BEEN ADVISED OF DIFFICULTIES DURING ANESTHESIA?	O	O
5. ARE YOU ALLERGIC TO PENICILLIN, CODEINE, VALIUM OR ANY OTHER DRUGS OR MEDICINES?	O	O
6. HAVE YOU EVER HAD ANY EXCESSIVE BLEEDING REQUIRING SPECIAL TREATMENT?	O	O
7. HAVE YOU EVER HAD ANY OF THE FOLLOWING? (CIRCLE)	O	O

HEART TROUBLE	ASTHMA	ARTHRITIS
VENEREAL DISEASES	DIABETES	CONGENITAL HEART LESIONS
STROKE	HIV POSITIVE	HEART MURMUR
TUBERCULOSIS	EPILEPSY OR SEIZURES	HIV POS/AIDS
HIGH BLOOD PRESSURE	HEPATITIS	PSYCHIATRIC TREATMENT
ANEMIA	JAUNDICE	SINUS TROUBLE
RHEUMATIC FEVER	GLAUCOMA	DIFFICULTY BREATHING

8. HAVE YOU HAD ANY OTHER SERIOUS ILLNESSES?	O	O
9. (WOMEN) ARE YOU PREGNANT NOW?	O	O
10. (WOMEN) ARE YOU TAKING ANY BIRTH CONTROL PILLS?	O	O

11. PERMISSION: I HEREBY AGREE AND GIVE MY UNQUALIFIED CONSENT TO ANY EXAMINATIONS, ANESTHETIC, TREATMENT THAT THE ATTENDING PHYSICIAN, DENTIST OR ASSISTANTS MAY DEEM NECESSARY OR ADVISABLE.

12. REFERRED BY _____

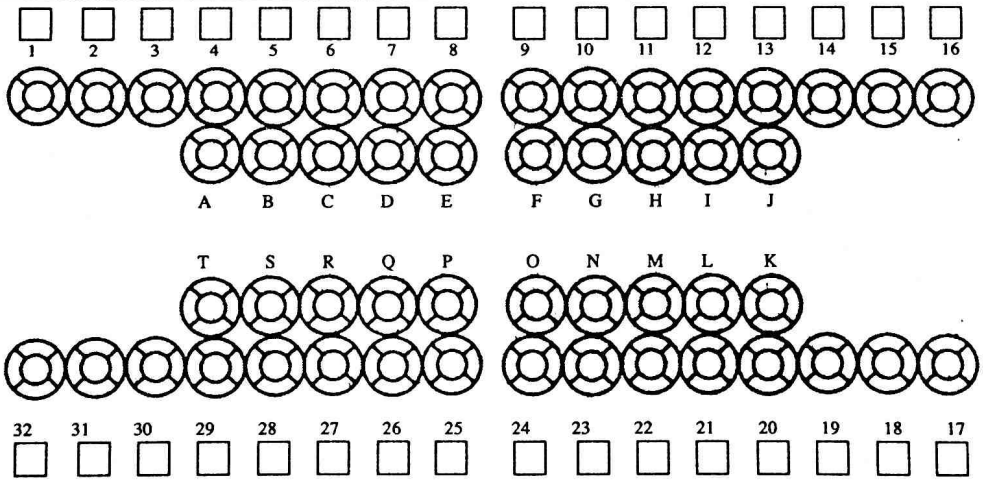
SIGNED _____
PATIENT OR NEAREST RELATIVES IN THE CASE WHEN THE PATIENT IS A MINOR OR PHYSICALLY OR MENTALLY INCOMPETENT.

OCCUPATION:

FINANCIAL ARRANGEMENT PVT. O INS. O

RELATIONSHIP TO SUBSCRIBER
SELF O SPOUSE O DEPENDENT O

PRIMARY INS.	SECONDARY INS.
NAME OF INSURANCE CO.	NAME OF INSURANCE CO.
NAME OF POLICY HOLDER	NAME OF POLICY HOLDER
POLICY HOLDERS S.S.#	POLICY HOLDERS S.S.#
DATE OF BIRTH	DATE OF BIRTH
EMPLOYER'S NAME, ADDRESS & PHONE NUMBER	EMPLOYER'S NAME, ADDRESS & PHONE NUMBER



PERDONTAL EXAMINATION
INFLAMATION OF

GINGIVAL TISSUE	☐ SLIGHT	☐ MODERATE	☐ SEVERE	OTHER: _____
CALCULUS	☐ SLIGHT	☐ MODERATE	☐ SEVERE	_____
RECESSION	☐ SLIGHT	☐ MODERATE	☐ SEVERE	_____
