Victor Apel, DMD
1514 S Babcock St.
Melbourne, FL 32907
https://www.melbournefloridadental.com/

Please take a few minutes to fill out the following forms as completely as you can. If you have any questions we'll be glad to assist you. We look forward to working with you in maintaining your dental health.

PATIENT INFORMATION

Patient Name: _____ Date: _____
Last *First* *MI*

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other: _____

Social Security #: _____ Date of Birth: _____

Phone (Home): _____ Phone (Cell): _____

E-mail: _____

Address: Street: _____ Apt #: _____

City: _____ State: _____ Zip Code: _____

EMPLOYMENT INFORMATION

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Address: Street: _____ Apt #: _____

City: _____ State: _____ Zip Code: _____

EMERGENCY CONTACT INFORMATION

Name: _____ Relation: _____ Phone: _____

REFERRAL INFORMATION

How did you learn about our practice? ☐ TV Show ☐ TV Commercial Channel? _____

☐ Mini Implant Website ☐ Dr. Apel Website ☐ Other Website? _____

☐ Another patient, friend ☐ Another patient, relative ☐ Another doctor ☐ Other: _____

Name of person or office referring you to our practice: _____

Victor Apel, DMD
1514 S Babcock St.
Melbourne, FL 32907
https://www.melbournefloridadental.com/

MEDICAL HISTORY

PATIENT NAME: _____ DATE OF BIRTH: _____

Although dental personnel primarily treat the area in and around your mouth. Your mouth is a part of your entire body, health problems that you may have or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thanks you for answering the following questions.

1. PLEASE CHECK YES OR NO:

Are you under physicians care now? ☐ YES or ☐ NO If yes, please explain_____

Physicians Name and phone #_____

Have you ever been hospitalized or had a major operation? ☐ YES or ☐ NO If yes, please explain_____

Have you ever had a serious head or neck injury? ☐ YES or ☐ NO If yes, please explain_____

Are you taking any medications, pills or drugs? ☐ YES or ☐ NO If yes, please explain_____

_____

Do you take or have you taken Phen-Fen or Redux? ☐ YES or ☐ NO If yes, please explain_____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ☐ YES or ☐ NO If yes, please explain_____

Are you on special diet? ☐ YES or ☐ NO If yes, please explain_____

Do you use tobacco? ☐ YES or ☐ NO If yes, please explain (HOW MANY CIGARETTES PER DAY) _____

Have you ever taken controlled substances? ☐ YES or ☐ NO If yes, please explain_____

Have you ever been under the care of a Pain Management Physician? ☐ YES or ☐ NO If yes, please explain_____

2. WOMEN: Are you Pregnant/Trying to get pregnant? ☐ YES or ☐ NO Taking Oral Contraceptives? ☐ YES or ☐ NO Nursing? ☐ YES or ☐ NO

3. ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Metal ☐ Latex ☐ Sulfa ☐ No Known Drug Allergies ☐ OTHER

4. DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING?

AIDS/HIV Positive	☐ YES ☐ NO	Cortisone Medicine	☐ YES ☐ NO	Hemophilia	☐ YES ☐ NO	Radiation Treatments	☐ YES ☐ NO
Alzheimer's Disease	☐ YES ☐ NO	Diabetes	☐ YES ☐ NO	Hepatitis A	☐ YES ☐ NO	Recent Weight Loss	☐ YES ☐ NO
Anaphylaxis	☐ YES ☐ NO	Drug Addiction	☐ YES ☐ NO	Hepatitis B or C	☐ YES ☐ NO	Renal Dialysis	☐ YES ☐ NO
Anemia	☐ YES ☐ NO	Easily Winded	☐ YES ☐ NO	Herpes	☐ YES ☐ NO	Rheumatism	☐ YES ☐ NO
Angina	☐ YES ☐ NO	Emphysema	☐ YES ☐ NO	High Blood Pressure	☐ YES ☐ NO	Scarlet Fever	☐ YES ☐ NO
Arthritis/Gout	☐ YES ☐ NO	Epilepsy or Seizures	☐ YES ☐ NO	High Cholesterol	☐ YES ☐ NO	Shingles	☐ YES ☐ NO
Artificial Heart Valve	☐ YES ☐ NO	Excessive Bleeding	☐ YES ☐ NO	Hives or Rash	☐ YES ☐ NO	Sickle Cell Disease	☐ YES ☐ NO
Artificial Joint	☐ YES ☐ NO	Excessive Thirst	☐ YES ☐ NO	Hypoglycemia	☐ YES ☐ NO	Sinus Trouble	☐ YES ☐ NO
Asthma	☐ YES ☐ NO	Fainting Spells/Dizziness	☐ YES ☐ NO	Irregular Heartbeat	☐ YES ☐ NO	Spine Bifida	☐ YES ☐ NO
Blood Disease	☐ YES ☐ NO	Frequent Cough	☐ YES ☐ NO	Kidney Problems	☐ YES ☐ NO	Stomach/Intestinal Disease	☐ YES ☐ NO
Blood Transfusion	☐ YES ☐ NO	Frequent Diarrhea	☐ YES ☐ NO	Leukemia	☐ YES ☐ NO	Stroke	☐ YES ☐ NO
Breathing Problem	☐ YES ☐ NO	Frequent Headaches	☐ YES ☐ NO	Liver Disease	☐ YES ☐ NO	Swelling of Limbs	☐ YES ☐ NO
Bruise Easily	☐ YES ☐ NO	Genital Herpes	☐ YES ☐ NO	Low Blood Pressure	☐ YES ☐ NO	Thyroid Disease	☐ YES ☐ NO
Cancer	☐ YES ☐ NO	Glaucoma	☐ YES ☐ NO	Lung Disease	☐ YES ☐ NO	Tonsillitis	☐ YES ☐ NO
Chemotherapy	☐ YES ☐ NO	Hay fever	☐ YES ☐ NO	Mitral Valve Prolapse	☐ YES ☐ NO	Tuberculosis	☐ YES ☐ NO
Chest Pains	☐ YES ☐ NO	Heart Attack/Failure	☐ YES ☐ NO	Osteoporosis	☐ YES ☐ NO	Tumors Growths	☐ YES ☐ NO
Cold Sores/Fever Blisters	☐ YES ☐ NO	Heart Murmur	☐ YES ☐ NO	Pain in Jaw Joints	☐ YES ☐ NO	Ulcers	☐ YES ☐ NO
Congenital Heart Disorder	☐ YES ☐ NO	Heart Pacemaker	☐ YES ☐ NO	Parathyroid Disease	☐ YES ☐ NO	Venereal Disease	☐ YES ☐ NO
Convulsions	☐ YES ☐ NO	Heart Trouble/Disease	☐ YES ☐ NO	Psychiatric Care	☐ YES ☐ NO	Yellow Jaundice	☐ YES ☐ NO

5. HAVE YOU EVER HAD ANY SERIOUS ILLNESS NOT LISTED ABOVE? ☐ YES or ☐ NO

If YES, please explain: _____

_____

To the best of my knowledge the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT OR GUARDIAN _____ DATE _____

PATIENT DENTAL HISTORY

	YES	NO
1. Do your gums bleed while brushing or flossing?	☐	☐
2. Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
3. Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐
4. Do you feel pain to any of your teeth when you apply pressure or bite down?	☐	☐
5. Do you currently have or have you had any sores or lumps in or near your mouth?	☐	☐
6. Have you had any head neck or jaw injuries?	☐	☐
7. Have you experienced any of the following problems in your jaw?		
a) Clicking?	☐	☐
b) Pain (joint, ear, side of face)?	☐	☐
c) Difficulty in opening or closing?	☐	☐
d) Difficulty in chewing?	☐	☐
8. Do you have frequent headaches?	☐	☐
9. Do you clench or grind your teeth?	☐	☐
10. Have you noticed that your bite has changed or that any teeth have moved?	☐	☐
11. Do you bite your lips or cheeks frequently?	☐	☐
12. Have you ever had any difficult extractions in the past?	☐	☐
13. Have you ever had any orthodontic work (braces)?	☐	☐
14. Have you ever had prolonged bleeding following extractions?	☐	☐
15. Do you have food traps?	☐	☐
16. Have you noticed any swelling or redness of your gums?	☐	☐
17. Have you noticed or has anyone said you have "bad breath"?	☐	☐
18. Do you snore?	☐	☐
19. Do you have difficulty sleeping?	☐	☐
20. Have you been diagnosed with sleep apnea?	☐	☐
21. Have you ever had instruction on the correct method of brushing your teeth?	☐	☐
22. Have you ever had instruction on the care of your gums?	☐	☐

Date of Last Dental Visit/Exam:_____ Name of Dentist:_____

Address: _____ Office Phone:_____

What was done at your last dental visit? _____

_____

Do you have any dental problems now? ☐ YES ☐ NO

If yes, please describe:_____

_____

_____

Are you unhappy with a specific tooth or teeth? ☐ YES ☐ NO

Do you have discolored teeth that bother you? ☐ YES ☐ NO

Would you like your smile to look better or different? ☐ YES ☐ NO

What would you change about your smile? _____

_____

Is there anything else about having dental treatment you would like us to know? ☐ YES ☐ NO

If yes, please describe:_____

_____

_____

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

SIGNATURE X_____ DATE

PATIENT, PARENT OR GUARDIAN

08/2012

DESIGNING SMILES, LLC

1514 South Babcock Street
Melbourne, FL 32901

Telephone (321) 727-1320
Fax (321) 727-8474

Thank you for choosing our office for your dental needs. Dr. Apel and the staff prepare for and treat each patient on an individual basis. Prior to treatment we will give an estimate of the amount due for each visit. Payment is due at the time of service. (we accept cash, checks, Mastercard, Visa, Discover, Care Credit and Lending Club.

For patient with insurance... As a courtesy to you, we will file charges to your insurance company. Our front office has experience with insurance and will assist with any questions or concerns. Please be aware that all charges are your responsibility - whether your insurance company pays or not. **Your insurance policy is a contract between you and your insurance company. We are not party to that contract.** Should your insurance company not pay within five weeks, you will be required to pay in full at that time; any subsequent payment will be credited to your account or a reimbursement check will be mailed to you.

Appointments and Payments... Our office expects you to keep your appointments and be prepared to pay for services at the time they are rendered. Unless we are notified at least 48 hours in advance, there is a $50.00 fee charged for missed/broken appointments, and this fee is required prior to rescheduling. We would appreciate two or more days notice of any changes as this allows us ample time to schedule other patients who are waiting for appointments. Please be timely with your payments. Late payments will incur a late fee of $20.00 per month plus a 1.5% charge (18% annual rate) will apply to all unpaid balances. There is a $30.00 fee for any returned checks.

Treatment of minors... Parents must consent for treatment and prearrange payments for unaccompanied minors. (to include patients brought in by grandparents, friends, etc.).

I have read the above office policies and I understand and will abide by them.

_____ _____

Signature of Patient/Guardian Date

_____

Witness

DESIGNING SMILES, LLC

1514 South Babcock Street
Melbourne, FL 32901

Telephone (321) 727-1320
Fax (321) 727-8474

Dear Patient:

We at Dr. Apel's office are proud to be part of a team whose primary mission is to deliver the finest and most comprehensive dental service available today. Thank you for choosing us as your health care provider. We are committed to providing you with a positive treatment experience.

Please understand payment of your bill is considered a part of your treatment, the following is a statement of our financial policy, which we require you to read and sign prior to any treatment. All patients must complete our information and our insurance agreement forms before seeing the doctor.

- FULL PAYMENT is due at the time of service.
- WE ACCEPT Cash, Checks, or Visa/Mastercard/Discover
- WE OFFER a financial service through Care Credit and Lending Club

Minor Patients
The adult accompanying a minor and the parent (or guardian of the minor) is responsible for full payment. For unaccompanied minor, treatment cannot be provided without prior authorization by the parent or guardian.

Regarding Insurance
Usual and customary rates

Since your insurance carrier must make a profit, you can only get back in benefits what you or your employer has put into the program, minus the profit. In other words, your particular insurance program may base its dollar allowance on a fee schedule, which does not realistically coincide with current, acceptable fees.

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. Your are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

We may accept assignment of insurance benefits on your second visit. However, we do require your percentage of the bill to be paid at the time of service. The balance is your responsibility whether or not your insurance company pays. We cannot bill your insurance company unless you give us your insurance information. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. If your insurance company has not paid your account in full within 90 days, the balance will automatically be the patient's responsibility. All account balances will be subject to a finance charge of 1.5% monthly (18% APR) after 120 days. Please be aware that some of the services provided may be non-covered services and not considered reasonable and necessary under the insurance program and/or dental insurance.

If there is a balance after 90 days, the balance will automatically be the patient's responsibility. This balance will be charged to a credit card. In the rare event that your account becomes delinquent you are responsible for all fees of collection including, but not limited to, attorney's fees and legal costs.

I, _____ authorize Dr. Apel to withdraw payments from the credit card listed below. _____Visa _____Mastercard _____Discover
Credit Card Number: _____ Exp. Date _____
Security Code: _____
Signature: _____ Date: _____

Please circle the method of payment you are most likely to use:
CASH CHECK VISA MASTERCARD DISCOVER CARE CREDIT LENDING CLUB

Thank you for understanding our financial policy. Please let us know if you have questions or concerns. I have read the financial policy. I understand and agree to this financial policy.

_____
Print Patient Name

_____ _____
Signature of Patient/Guardian or Responsible Party Date

Victor Apel, DMD
1514 S Babcock St.
Melbourne, FL 32907
https://www.melbournefloridadental.com/

PATIENT CONSENT FORM

I understand that, under the **Health Insurance Portability & Accountability Act of 1996 (HIPAA)**, I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among multiple Healthcare providers who may be involved in that treatment directly and Indirectly
- Obtain payment from third-party payer
- Conduct normal healthcare operations such as quality assessments and Physician certifications

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Private Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand Dr. Apel office is not required to agree to my requested, restrictions, but if they do agree then they would be bound to abide by such restrictions.

Patient Name: _____
Signature: _____
Date: _____