SIMONY DENTAL GROUP

Welcome to our office! We appreciate the confidence you place with us to provide dental services. To assist us in serving you, please complete the following forms. The information provided on these forms is important to your dental health. If there have been any changes in your health, please let us know.

PATIENT INFORMATION

DATE: _____

FIRST NAME: _____ MI: _____ LAST NAME: _____

DATE OF BIRTH: _____ EMAIL: _____

SEX: MALE: _____ FEMALE: _____ EMERGENCY CONTACT#: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME#: _____CELL#: _____ WORK#: _____

MARITAL STATUS: SINGLE: _____ MARRIED: _____ DIVORCED: _____ WIDOWED: _____

SSN#: _____-_____-_____ DRIVER'S LICENSE #: _____

WHO MAY WE THANK FOR YOUR REFERRAL? _____

RESPONSIBLE PARTY (IF PATIENT IS A MINOR): _____

** Please be aware that any parent or guardian bringing a minor into our office is legally responsible for the payment of the services rendered on that day. **

DENTAL INSURANCE INFORMATION

PRIMARY DENTAL INSURANCE COMPANY: _____

POLICY HOLDER NAME: _____ DATE OF BIRTH: _____

POLICY HOLDER'S SSN OR MEMBER ID#: _____

RELATIONSHIP TO PATIENT: _____ INSURANCE PHONE #: _____

SECONDARY INSURANCE COMPANY: _____

POLICY HOLDER NAME: _____ DATE OF BIRTH: _____

POLICY HOLDER'S SSN OR MEMBER ID#: _____

RELATIONSHIP TO PATIENT: _____ INSURANCE PHONE #: _____

SIMONY DENTAL GROUP

DENTAL INFORMATION

CHIEF ORAL COMPLAINT: _____

DATE OF LAST DENTAL EXAM: _____ CLEANING: _____ XRAYS: _____

PREVIOUS DENTIST CONTACT INFORMATION: _____

How satisfied are you with your smile?

PLEASE INDICATE IF YOU HAVE ANY OF THE FOLLOWING DENTAL CONCERNS

___ SENSITIVITY TO HOT OR COLD	___ CHANGES IN YOUR BITE
___ SENSITIVITY TO PRESSURE OR SWEETS	___ CLENCHING OR GRINDING OF TEETH
___ BLEEDING OR PAINFUL GUMS	___ CLICKING OR POPPING JAW
___ SWELLING OR LUMPS IN THE MOUTH	___ HEAD, NECK OR SHOULDER PAIN
___ LOOSE TEETH	___ DIFFICULTY OPENING OR CLOSING MOUTH
___ UNPLEASANT TASTE IN YOUR MOUTH	___ MOUTH BREATHING OR SNORING
___ BLISTERS ON, OR IN MOUTH	___ JAW OR EAR PAIN

HAVE YOU EVER HAD:

ORTHODONTIC TREATMENT? _____
PERIODONTAL DISEASE TREATMENT? _____
BITEGUARD OR SLEEPGUARD? _____
COMPLICATIONS FROM AN EXTRACTION? _____

HOW OFTEN DO YOU FLOSS? _____
HOW OFTEN DO YOU BRUSH? _____

Have you ever had an upsetting dental experience? _____
_____
_____

Is there anything else that you would like us to know? _____
_____
_____

SIMONY DENTAL GROUP

MEDICAL HISTORY

PLEASE INDICATE IF YOU CURRENTLY HAVE, OR HAVE HAD HISTORY OF ANY OF THE FOLLOWING CONDITIONS

CARDIOVASCULAR/HEMATOLOGIC	GASTROINTESTINAL/ENDOCRINE	NEUROLOGIC/SENSORY
__ Heart Failure, Disease or Attack __ Chest Pain __ High Blood Pressure __ Low Blood Pressure __ Congenital Heart Defect or Lesion __ Artificial Heart Valves __ Arrhythmias __ Heart Pacemaker or Defibrillator __ Heart Surgery or Transplant __ Mitral Valve Prolapse __ Stroke __ Aneurysm __Blood Transfusion __ Anemia __ Hemophilia __ Leukemia __ Sickle Cell Anemia Disease __ Bleeding Disorders __ Currently Taking Blood Thinners.	__ Ulcers __ GERD or Acid Reflux __ Gastritis __ Colitis __ Hepatitis A/B/C __ Lymes Disease __ Cirrhosis __ Jaundice __ Diabetes __ Thyroid Problems __ Autoimmune Disorders	__ Eye Pain __ Vision Problems __ Glaucoma or Cataracts __ Earaches or Ringing in Ears __ Hearing Loss __ Severe Headaches __ Fainting or Dizzy Spells __ Epilepsy __ Seizures or Convulsions __ Nervousness __ Anxiety __ Neuro/Psych disorders __ Psychiatric Treatment
RESPIRATORY	**URINARY/REPRODUCTIVE**	**OTHER**
__ Hay fever __ Sinus Problems __ Allergies or Hives __ Asthma __ Chronic Cough __ Emphysema __ Tuberculosis (TB) __ Breathing Problems	__ Currently Pregnant __ Currently Breastfeeding __ AIDS __ Kidney/Bladder Problems __ HIV Positive __ Cold Sores/Herpes __ Other Sexually Transmitted Disease	__ Latex Allergy __ Skin Rash __ Arthritis __ Mouth Ulcers/Canker Sores __ Rheumatic fever __ Artificial joints __ Tumor/Cancer __ Radiation therapy __ Chemotherapy __ Currently Taking Medication or Injections for Osteoporosis or arthritis.

Do you have any other conditions that you would like us to be aware of? _____

_____

HAVE YOU BEEN UNDER THE CARE OF A MEDICAL DOCTOR IN THE PAST 2 YEARS FOR AN ONGOING CONDITION? PLEASE GIVE DETAILS: _____

_____

_____

PRIMARY CARE PROVIDER: _____ PHONE#: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

SIMONY DENTAL GROUP

What medications are you currently taking? (If you have a list, we can make a copy for you): ___

_____

_____

Are you required to take a pre-medication before dental treatment? _____

Do you have any allergies to medications? _____

Have you been hospitalized in the past five years? -If yes please describe. _____

_____

_____

Do you drink alcohol, how often? _____

Do you use tobacco, how often? _____

Do you use recreational drugs, how often? _____

Do you have any history of drug or alcohol abuse? _____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

Signature: _____ Date: _____

SIMONY DENTAL GROUP

FINANCIAL AGREEMENT

We are committed to providing you with the best dental care as we follow the ADA recommended guidelines. Our fees reflect our professional commitment to excellence. If you have dental insurance, we are happy to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and understanding of our payment policies. For your convenience we offer the following financial options to pay for your dental treatment:

Option 1: PAY AS YOU GO- we require that you pay your total obligation with cash, check or credit card at that visit.
Option 2: CARE CREDIT- Care Credit offers NO INTEREST FINANCING for up to 12 months and low monthly payment options. There are no upfront costs, no prepayment penalties and no fee as long as it is paid in full by the end of the term. This allows you to get the necessary work done now, and pay later.

Please be aware that your dental benefit program is a contract between you, your employer and the insurance company. We are not a party to that contract. We file claims as a courtesy to you, our valued patient. You are responsible (not your insurance company) for all fees of services rendered.

APPOINTMENT AGREEMENT

Your appointment is a commitment of time between you and our office. If you find that you cannot keep your appointment, contact our office within 48 hours to make other arrangements. If you do not make the office aware of this change, you will be subject to a $50.00 cancellation fee.

PRIVACY PRACTICES

As our patient we want you to know that we respect the privacy of your personal dental records and will do all that we can to secure and protect that privacy. When it is appropriate and necessary, we provide minimum information only to those who we feel are in need of your health care. You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing.

I certify that I have read, fully understand and accept the above financial policy, appointment agreement and privacy practices.

Signature: _____ Date: _____

SIMONY DENTAL GROUP

PERSONAL INFORMATION/RECORDS RELEASE FORM

I (NAME)_____, give Dr. Michael Simony and his staff permission to leave a detailed message on my home, cell or work phone regarding my medical condition, prescription refills or billing matters.

Signature: _____ Date: _____

I (NAME)_____, give Dr. Michael Simony and his staff authorization to release personal information regarding my dental treatment and/or finances to (NAME)_____ (RELATIONSHIP)_____

Signature: _____ Date: _____

I (NAME)_____, consent to the release of my dental records and/or x-rays upon my request to another dental office or to my personal email.

Signature: _____ Date: _____

EMAIL: _____

SIMONY DENTAL
GROUP

PHOTOGRAPHY RELEASE FORM

I _____, authorize and consent to the use of my photographs or x-rays taken by Simony Dental Group.

I grant Simony Dental permission to reproduce, print and publish photographs taken of me in a professional publication or in the form of prints, film or slides in connection with articles and lectures dealing with the jaw or dental disorders.

I consent to the use of my photographs or images for patient education purposes only.

I understand that if my images are used, my name or any identifying information will not be used. No full face or comparable photos will be used without your express written authorization.

I further acknowledge that my participation is voluntary and that I will not receive any compensation, financial or otherwise, with respect to the taking, use or publication of these photographs for any dental office publications.

I acknowledge and agree that publication of photographs confers no rights of ownership or royalties whatsoever.

Patient's Name: _____

Patient or Guardian Signature: _____

Dentist Signature: _____Date: _____