Patient Information

Welcome to Simply Dentistry! We appreciate and value the confidence you have placed with us in providing you excellent dental care. To assist us in serving you, please complete the following form. The information provided on this form is important to your dental health. If there have been any recent changes to your health, please tell us. If you have any questions, please don't hesitate to ask.

Patient name: _____ Date of birth: _____ Sex: _____ Age: _____

Home address: _____ City: _____ State: _____ Zip: _____

Biling address (if different): _____ City: _____ State: _____ Zip: _____

Home phone: _____ Cell: _____ E-mail: _____

SS#: _____ Employer/Occupation: _____ Bus. Phone: _____

Spouse's name & phone#: _____ Emergency phone # (other than spouse): _____

Primary dental insurance: _____ Group#: _____

Secondary dental insurance: _____ Group#: _____

Subscriber's name: _____ Date of birth: _____ SS#: _____

Name of your medical doctor: _____ Date of last visit to medical doctor: _____

Name of previous dentist: _____ Date of last visit to dentist: _____

Referred to us by: _____

Dental Health History

	Yes	No		Yes	No
Are you apprehensive about dental treatment?	□	□	How often do you floss?	□	□
Have you had problems with previous dental treatment?	□	□	Does your jaw make noise so that it bothers you or others?	□	□
Do you gag easily?	□	□	Do you clench or grind your jaws frequently?	□	□
Do you wear dentures?	□	□	Do your jaws ever feel tired?	□	□
Does food catch between your teeth?	□	□	Does your jaw get stuck so that you can't open freely?	□	□
Do you have difficulty in chewing your food?	□	□	Does it hurt when you chew or open wide to take a bite?	□	□
Do you chew on only one side of your mouth?	□	□	Do you have earaches or pain in front of the ears?	□	□
Do you avoid brushing any part of your mouth because of pain?	□	□	Do you have any jaw symptoms or headaches upon awaking in the morning?	□	□
Do your gums bleed easily?	□	□	Does jaw pain or discomfort affect your appetite, sleep, daily routine, or other activities?	□	□
Do your gums bleed when you floss?	□	□	Do you find jaw pain or discomfort extremely frustrating or depressing?	□	□
Do your gums feel swollen or tender?	□	□	Do you take medications or pills for pain or discomfort (pain relievers, muscle relaxants, antidepressants)?	□	□
Have you ever noticed slow-healing sores in or about your mouth?	□	□	Do you have a temporomandibular (jaw) disorder (TMD)?	□	□
Are your teeth sensitive?	□	□	Do you have pain in the face, cheeks, jaws, joints, throats or temples?	□	□
Do you feel twinges of pain when your teeth come in contact with:			Are you unable to open your mouth as far as you want?	□	□
Hot foods or liquids?	□	□	Are you aware of an uncomfortable bite?	□	□
Cold foods or liquids?	□	□	Have you had a blow to the jaw (trauma)?	□	□
Sours?	□	□	Are you a habitual gum chewer or pipe smoker?	□	□
Sweets?	□	□			
Do you take fluoride supplements?	□	□			
Are you dissatisfied with the appearance of your teeth?	□	□			
Do you prefer to save your teeth?	□	□			
Do you want complete dental care?	□	□			
How often do you brush?	□	□			

Medical History

	Yes	No

Heart Problems
- Chest pain ____ □ □
- Shortness of breath ____ □ □
- Blood pressure problem ____ □ □
- Heart Murmur ____ □ □
- Heart valve problem ____ □ □
- Taking heart medication ____ □ □
- Rheumatic fever ____ □ □
- Pacemaker ____ □ □
- Artificial Heart Valve ____ □ □

Blood problems
- Easy bruising Frequent nosebleeds ____ □ □
- Abnormal bleeding ____ □ □
- Blood Disease (anemia) ____ □ □
- Ever require a blood transfusion? ____ □ □

Allergy Problems
- Hay fever ____ □ □
- Sinus problems ____ □ □
- Skin rashes ____ □ □
- Taking allergy medication ____ □ □
- Asthma ____ □ □

Intestinal Problems
- Ulcers ____ □ □
- Weight gain or loss ____ □ □
- Special diet ____ □ □
- Constipation/Diarrhea ____ □ □
- Kidney or bladder problems ____ □ □

Bone or Joint Problems
- Arthritis ____ □ □
- Back or neck pain ____ □ □
- Joint replacement (e.g. total hip pins or implants) ____ □ □

Fainting Spells, Seizures, or Epilepsy ____ □ □

Stroke(s) ____ □ □

Frequent or severe headaches ____ □ □

Thyroid problems ____ □ □

Persistent cough or swollen glands ____ □ □

Premedications required by physician ____ □ □

Cancer/Tumor ____ □ □

Diabetes ____ □ □
- Frequent urination ____ □ □
- Thirsty or mouth is dry much of the time ____ □ □
- Family history of diabetes ____ □ □

Tuberculosis or other respiratory disease ____ □ □

Do you drink alcohol? ____ □ □
- If so, how much? ____

Do you smoke? ____ □ □
- If so, how much? ____

Hepatitis, jaundice or liver trouble ____ □ □

Herpes or other STD ____ □ □

HIV-positive/AIDS ____ □ □

Glaucoma ____ □ □

Do you wear contact lenses? ____ □ □

History of head injury? ____ □ □

Epilepsy or other neurological disease? ____ □ □

History of alcohol or drug abuse? ____ □ □

Do you have any disease, condition or problem not listed previously that you feel we should know about? ____ □ □
- If so, please describe: ____

Are you allergic, or have you reacted adversely, to any of the following?
- Local anesthetics ("Novocaine") □ □
- Penicillin or other antibiotics □ □
- Sulfa drugs □ □
- Barbituates, sedatives, or sleeping pills □ □
- Aspirin, Acetaminopohen, or Ibuprofen □ □
- Codeine, Demerol, or ther narcotics □ □
- Reqction to metals □ □
- Latex or rubber dam □ □
- Other: ____

Women
- Are you taking contraceptives or other hormones? ____ □ □
- Are you pregnant? ____ □ □
  - If so, expected delivery date: ____
- Are you nursing? ____ □ □
- Have you reached menopause? ____ □ □
  - If so, do you have any symptoms? ____

During the past 12 months, have you taken any of the following?
- Antibiotics or sulfa drugs □ □
- Anticoagulants (e.g. Coumadin) □ □
- High blood pressure medicine □ □
- Tranquilizers □ □
- Insulin, Orinase, or similar drug □ □
- Aspirin □ □
- Digitalis or drugs for heart trouble □ □
- Nitroglycerin □ □
- Cortisone (steroids) □ □
- Natural remedies □ □
- Nonprescription drug/supplements □ □
- Other: ____

Notes: ____

Patient/Parent Signature: ____ **Date:** ____

Dentist initial: ____

Updates: Patient initial: ____ Dentist Initial: ____ Date: ____

Simply Dentistry Financial Agreement and Patient Responsibilities

We are committed to providing you with the best possible care and helping you achieve your optimum oral health. Towards these goals, we would like to explain the financial and scheduling responsibilities of our practice.

Payment: Payment in full and/or any estimated co-payments are due at the time services are rendered. Financial arrangements and agreements are completed in advance of performing any treatment. We accept the following forms of payment: Vista, MasterCard, Discover, Checks, American Express, Care Credit and cash. If you elect to apply for third-party financing, such as Care Credit, we are required by law to provide you with a Credit for Dental Services Notice.

Dental Benefit Plans: Your dental benefit plan is a contract between you/ your employer and the dental benefit plan. Benefits and payments received are based on the terms of the contract negotiated between you/your employer and the plan. We are happy to help our patients with questions about their dental benefit plans to understand and maximize their coverage. Should the claim be denied or adjusted, the patients and/or guardians (guarantor) will be directly responsible for all financial charges. Should your insurance company fail to pay us on your behalf within 60 days of submitting the claim, we will convert the claim amount as due from you and bill you for the open balance.

Out-Of-Network dental benefit plans: It is the patient's responsibility to verify with the plan whether the plan allows patients to receive reimbursement for services from out-of-network providers and /or PPO providers. Our practice can file the claim with your Dental Benefit plan and receive reimbursement directly from the Dental Benefit plan (unless the Dental Benefit plan has stipulated otherwise and/or you as the patient has stipulated no) if you "assign benefits" to our office. In this circumstance, you are responsible to pay the total amount due if your Dental Benefit plan will not allow for "assignment of benefits" to our office, and/or any estimated co-payments due at the time of service if your Dental Benefit plan does allow assignment of benefits to our office. Keep in mind our estimated out-of-pocket expense and/or estimated co-payment is only an estimate. If our office does not contract with your Dental Benefit plan, we are not given an exact dollar amount for services. Our office can send in a pre-treatment estimate to your Dental Benefit plan for a more accurate out-of-pocket and/or estimated co-payment amount due. Any/all balances not paid by your Dental Benefit plan are the sole responsibility of the patient/or Legal Guardian.

Scheduling of Appointments: We reserve a specific amount of time needed for the Dentist and Hygienist for each procedure. When a patient cancels or reschedules an appointment, we require *48 business hours notice* so we may adjust our schedule accordingly. Notice must be given by phone as we do not accept cancellations via voicemail, email or text messaging. To maintain the utmost service and care, any appointment cancelled or rescheduled without 48 business hours notice is subject to a fee of $98.00. To also serve our patients in a timely manner, we may need to reschedule your appointment if you are late by more than 20 minutes. A deposit may be required to hold your appointment if you have a history of failed appointments and/or rescheduled appointments without the required 48 business hours notice. This fee will not be refunded should you miss or cancel your appointment without the required 48 business hours notice.

_____

Patient name (Please print)

_____

Patient and/or Legal Guardian Signature and/or Representative

_____

Date