simply dental

PATIENT INFORMATION

Patient Name: ______________________ (Last / First / MI) Date: __________

Social Security Number __________ Birth Date: __________ ☐ Male ☐ Female

Phone: __________ Work #: __________ Cell: __________

Address: __________ (Street / Apartment#)

__________ (City / State / Zip Code)

☐ Married
☐ Single
☐ Child
☐ Other

Employer __________ Position: __________

Employer Address: __________

Spouse's Name: __________ Spouse's Phone#: __________

Patient email (optional): __________

Person to contact in case of emergency: __________

Emergency Contact Phone #: __________

HEALTH INFORMATION

Date of Last Dental Visit: __________ Reason for this visit: __________

Do you have or have you had any of the following? ***Please check those that apply.***

			ALLERGIES:
☐ AIDS/HIV	☐ Heart Murmur	☐ Respiratory Problems	☐ Latex
☐ Anemia/Hemophilia	☐ Hepatitis/Jaundice	☐ Rheumatic Fever	☐ Sulfa
☐ Arthritis	☐ Herpes	☐ Sinus Problems	☐ Codeine
☐ Artificial Joints	☐ High Blood Pressure	☐ Skin Rashes/Hives	☐ Penicillin
☐ Asthma	☐ Kidney Disease	☐ Smoker	☐ Aspirin
☐ Blood Disease	☐ Liver Disease	☐ Spina Bifida	☐ Anesthetic
☐ Cancer/Tumor	☐ Low Blood Pressure	☐ Stomach Problems	☐ Epinephrine
☐ Diabetes	☐ Lung Disease	☐ Stroke	☐ Bananas
☐ Epilepsy/Seizures	☐ Nervous Disorders	☐ TMJ/Jaw Pain	☐ Avocados
☐ Excessive Bleeding	☐ Pacemaker	☐ Thyroid Disease	☐ Kiwis
☐ Fainting/Dizziness	☐ PRE-MED needed	☐ Ulcers	☐ Chestnuts
☐ Glaucoma	☐ Pregnancy	☐ Venereal Disease	☐ Other
☐ Heart - Mitral Valve Prolapse	Due:	☐ Other	
☐ Heart Disease	☐ Radiation Treatment	__________	__________

Have you ever had complications following dental treatment? ☐ YES ☐ NO

Are you presently taking any medications? ☐ YES ☐ NO Please List: __________

Are you now under the care of a physician? ☐ YES ☐ NO Please explain: __________

Name of Physician: __________ Phone Number: __________

Do you have any health problems that need further clarification? ☐ YES ☐ NO Please explain: __________

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have a change in my health information, I will inform the doctor at the next appointment.

Patient Signature: __________ Date: __________

REFERRAL INFORMATION

How did you hear about our office? ☐ Sign ☐ Coupon ☐ Location ☐ Google ☐ Other Internet Search

☐ Another patient: __________ ☐ Another Doctor: __________

Other: __________

Revised 5.06.14

RESPONSIBLE PARTY INFORMATION (IF OTHER THAN PATIENT)

Name: ____________________ Date: __________
Last First MI

Social Security Number __________ Birth Date: __________ ☐ Male ☐ Female

Phone: __________ Work #: __________ Cell: __________

Address: ____________________

Employer __________ Position: __________

Employer Address: ____________________

INSURANCE INFORMATION

The patient (or parent/legal guardian if the patient is a minor) will be responsible for the entire balance of the account regardless of insurance coverage. As a service to our patients, we will file insurance claims for you provided we can get verification and a break down of benefits from your insurance carrier prior to treatment. Once verification is received, we will calculate your out of pocket expense based on the information provided from your insurance company and our past experience with them. We will collect your estimated out of pocket expense at the time services are rendered. Once the actual insurance payment has been received, we will bill you or refund you any difference. Although we will file claims for you as a courtesy, your entire balance is your responsibility and begins aging at the time services are rendered. If insurance payment is not received within 30 days of your treatment, you will be billed and the balance will be due upon receipt.

Name of Insured: __________ Is insured a patient here? ☐ YES ☐ NO

Insured's Birth Date: __________ ID#: __________ Soc. Sec # __________

Insured's Address: ____________________

Insured's Employer: __________ Work Phone: __________

Patient's Relation to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other ☐ Ins. Group# __________

Insurance Company Name: __________ Phone #: __________

Insurance Address: ____________________

CONSENT FOR SERVICES

As a condition of my treatment by Dr John Clauss and his staff in this office, I understand that payment in full is due at the time services are rendered. I may pay with cash, personal check (upon approval), Visa, Mastercard, Discover, or American Express. I understand that all emergency dental services or any services performed after regular business hours must be paid in cash. A service charge of 12% per month will be charged on the unpaid balance of any account exceeding 60 days in aging regardless of insurance coverage.

I understand that this office has the right to charge me for failure to keep a scheduled appointment or for canceling an appointment without 48 hours advance notice. I understand that I will be charged a fee of $30 for the duplication and transfer of my dental records to myself or third party.

I understand that the fee estimate listed for any dental treatment is only an estimate and can only be extended for 90 days from the date of the estimate. I also understand that due to the nature of dental care, unforseen problems may arise during treatment, which may cause fees, or treatment to change.

In the event that my account becomes delinquent, I understand that future treatment will be delayed until the balance has been paid. I also understand that I shall be responsible for attorney fees, collection agency fees, costs of collections, court costs, and/or other expenses and fees if my accounts becomes delinquent.

I grant my permission to you and your assignee to telephone me at home or work to discuss matters related to this form.

Signature of Patient: ____________________ Date: __________

Revised 9.26.12

Acknowledgement of Receipt of

HIPPA

(Health Insurance Portability and Accountability Act)
for
Simply Dental

I, ____, have received and/or reviewed a copy of Simply Dental's health information privacy policies and procedures.

____

Patient's Signature Today's Date

I give my permission for you to share my protected health information with the following person(s):

____

____

Patient's Signature Today's Date

Patient Questionnaire

Name:
Are your teeth sensitive to hot, cold, sweets, or biting pressure?
Does food constantly get stuck between certain teeth in your mouth?
Are you unhappy with the way your teeth look?
Do any of your fillings show when you smile?
If any of your fillings need replaced, would you be interested in tooth colored fillings?
Have you ever had any teeth removed?
Do your gums bleed when brushing?
Do you have an unpleasant taste or odor in your mouth?
How often do you brush your teeth?
How often do you floss your teeth?
Has fear of discomfort kept you from regular dental visits?
Are you concerned about the finances required to return your mouth to excellent oral health?
What prompted you to seek dental care at this time?
Are you interested in teeth whitening?
On a scale from 1-10 (1=not important; 10= extremely important), how important are your teeth to you? 1 2 3 4 5 6 7 8 9 10