WELCOME TO SIMMONS DENTAL

The benefits of a happy, healthy smile are immeasurable!
Our goal is to help you reach and maintain maximum oral health.
Please fill out this form completely. The better we communicate, the better we can care for you.

1. ABOUT YOU

Today's Date: ______________________ **E-mail Address:** ______________________

Name: ______________________ I prefer to be called: ______________________

Birthdate: _____ /____/ _____ Age: __________ ❑ Male ❑ Female **SS #:** ______________________

Home Address: ______________________

❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Home #: (_____) ______________________ Work #: (_____) ______________________ Ext. __________

Pager / Cell #: ______________________ DL #: ______________________

Employer: ______________________ Employer's Address: ______________________

How long there? __________ Occupation: ______________________

Where and when are the best times to reach you? ______________________

Whom may we Thank for referring you? ______________________ Other family members seen by us: ______________________

Previous/Present Dentist: ______________________ Last Visit Date: ______________________

2. SPOUSE INFORMATION

His / Her Name: ______________________

Employer: ______________________ Work #: (_____) ______________________ Ext. __________

Birthdate: _____ /____ /_____ SS #: ______________________ DL #: ______________________

Person Responsible for Account: ______________________ Relation: ______________________

Home #: (_____) ______________________ Work #: (_____) ______________________ Ext. __________

Billing Address: ______________________

SS #: ______________________ DL #: ______________________ Employer: ______________________

3. DENTAL INSURANCE

Primary Insurance Co. Name: ______________________

Insurance Co. Address: ______________________

Insurance Co. Phone # (_____) ______________________

Group # (Plan, Local or Policy #): ______________________

Insured's Name: ______________________ Relation: __________

Insured's Birthdate: ___ /___ /____ Insured's ID#: ______________________

Insured's Employer: ______________________

Secondary Insurance Co. Name: ______________________

Insurance Co. Address: ______________________

Insurance Co. Phone # (_____) ______________________

Group # (Plan, Local or Policy #): ______________________

Insured's Name: ______________________ Relation: __________

Insured's Birthdate: ___ /___ /____ Insured's ID#: ______________________

Insured's Employer: ______________________

4. MEDICAL HISTORY

Do you have a personal physician? ❑ Yes ❑ No Physician's Name: ______________________

Phone #: ______________________ Last Visit Date: ______________________

Are you currently under the care of a physician? ❑ Yes ❑ No Please explain: ______________________

In the event of an emergency, is there someone who lives near you that we should contact?

His/Her Name: ______________________ Relation: ______________________

Work #: (_____) ______________________ Home #: (_____) ______________________

5. MEDICAL HISTORY continued

Your current physical health is: ❑ Good ❑ Fair ❑ Poor   Do you smoke or use tobacco in any form? ❑ Yes ❑ No

Are you taking any prescription / over-the-counter or herbal supplement drugs? ❑ Yes ❑ No

Please list each one: ____________________

Have you ever taken Fosamax, or any other bisphosphonate? ❑ Yes ❑ No   Have you ever taken Phen-Fen? ❑ Yes ❑ No

For Women: Are you using a prescribed method of birth control? ❑ Yes ❑ No

Are you pregnant? ❑ Yes ❑ No   Week #: ________   Are you nursing? ❑ Yes ❑ No

Have you ever had any of the following diseases or medical problems?

Y	N	Abnormal Bleeding	Y	N	Frequent Headaches	Y	N	Lupus
Y	N	Alcohol / Drug Abuse	Y	N	Glaucoma	Y	N	Mitral Valve Prolapse
Y	N	Anemia	Y	N	Hay Fever	Y	N	Pacemaker
Y	N	Arthritis	Y	N	Heart Attack	Y	N	Psychiatric Problems
Y	N	Artificial Bones/Joints/Valves	Y	N	Heart Murmur	Y	N	Radiation Treatment
Y	N	Asthma	Y	N	Heart Surgery	Y	N	Rheumatic/Scarlet Fever
Y	N	Blood Transfusion	Y	N	Hemophilia	Y	N	Seizures
Y	N	Cancer/Chemotherapy	Y	N	Hepatitis	Y	N	Shingles
Y	N	Colitis	Y	N	Herpes/Fever Blisters	Y	N	Sickle Cell Disease
Y	N	Congenital Heart Defect	Y	N	High Blood Pressure	Y	N	Sinus Problems
Y	N	Diabetes	Y	N	HIV+/AIDS	Y	N	Stroke
Y	N	Difficulty Breathing	Y	N	Hospitalized for Any Reason	Y	N	Thyroid Problems
Y	N	Emphysema	Y	N	Kidney Problems	Y	N	Tuberculosis (TB)
Y	N	Epilepsy	Y	N	Liver Disease	Y	N	Ulcers
Y	N	Fainting Spells	Y	N	Low Blood Pressure	Y	N	Venereal Disease

Please list any medical condition(s) that you have ever had: ____________________

Are you allergic to any of the following:

Y	N	Aspirin	Y	N	Erythromycin	Y	N	Penicillin
Y	N	Codeine	Y	N	Jewelry / Metals	Y	N	Tetracycline
Y	N	Dental Anesthetics	Y	N	Latex	Y	N	Other

Please list any other drugs/materials that you are allergic to: ____________________

6. DENTAL HISTORY

Why have you come to the dentist today? ____________________

Has your doctor told you that you require antibiotics before dental treatment? ❑ Yes ❑ No

Are you currently in pain? ❑ Yes ❑ No

Have you ever had a serious/difficult problem associated with any previous dental work? ❑ Yes ❑ No

Do you or have you ever experienced pain / discomfort in your jaw joint (TMJ/TMD)? ❑ Yes ❑ No

Your current dental health is: ❑ Good ❑ Fair ❑ Poor   Do you like your smile? ❑ Yes ❑ No

Do your gums ever bleed? ❑ Yes ❑ No   How many times a week do you floss? ________

How many times a day do you brush? ________   Type of bristles? ❑ Hard ❑ Medium ❑ Soft

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

Signature ____________________ **Date** ________

Payment is due in full at time of treatment unless prior arrangements have been approved.

Thank you for filling out this form completely. It will enable us to help you more effectively. If you have a question at any time, please ask us. We are happy to help.

Our office is HIPAA Compliant and committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

OFFICE USE ONLY

I verbally reviewed the medical / dental information above with the patient named herein. **Initials** ________ **Date** ________

Doctor's comments: ____________________

MEDICAL HISTORY UPDATE

1. Date: ________ **Comments:** ____________________ **Signature:** ________

2. Date: ________ **Comments:** ____________________ **Signature:** ________

3. Date: ________ **Comments:** ____________________ **Signature:** ________