WELCOME

The benefits of a healthy, beautiful smile are immeasurable and our goal is to allow you to obtain the healthy and attractive smile you want and deserve. Please complete this form so that we can provide the best care possible for you.

ABOUT YOU Today's Date:

Name:____

I prefer to be called: ____________________ Whom may we thank for referring you: ____________

Date of Birth: ________________________ Sex: _________Male ___________Female

Home Address: ____ Zip ______

Employer:____________________________Occupation: ______________________Years Employed

Employer Address: ____

Social Security Number: _______ - _______-______ Driver's License Number: ____________

Marital Status: Single______ Married _____ Divorced______ Widowed ______

Spouses' Name: ________________________________

Spouses'Social Security Number: ______-_____ - ____ Spouses'Date of Birth: ______________

FULL-TIME STUDENTS ONLY

School Name: ____ School Phone Number:____________

School Address:____

TELEPHONE INFORMATION

Home Phone:________________________

Work Phone: _______________________ Cell Phone: ____________________________________

Pager Number: _____________________ Email: ____

In case of emergency, is there someone we can call? Name:__________________________________

Address: ____ Phone Number:______________________

INSURANCE INFORMATION Insured’s Name:____

Insurance Company: ________________________________ Group Number:_________________

Insurance Company Address:____

Insurance Company Phone Number: ____________________ Insured's Employer:_________________

Secondary Insurance Company (if any): __________________________________

Insured's Name: ___________________________________ Group Number:_____________

Insurance Company Address: ____

Insurance Company Phone Number: ____________________

Insured’s Employer:__________________________________

MEDICAL HISTORY

Name of physician: _______________

Phone Number: Date of Last Visit:

Current Health: Excellent Good Fair Poor

Do you smoke or use tobacco? Yes No If yes, how much per day:

Are you currently taking prescription medications?

Yes____ No____ If Yes please list below:

Name of medication:_______________________ Purpose:

____ Purpose:

Have you had any serious medical conditions within the past 5 years? Yes No

If yes, please explain: ____

FOR WOMEN ONLY

Are you or could you be pregnant:______ Yes ________ No If yes, how many months?

Are you nursing?_____ Yes _____ No Are you taking birth control pills?____ Yes_____ No

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

Y N Heart Disease/Attack	Y N Hepatitis/Jaundice	Y N Heart Murmur/Rheumatic Fever
Y N Cancer/Chemotherapy	Y N Abnormal Bleeding	Y N Epilepsy/Seizures/Fainting
Y N Drug/Alcohol Abuse	Y N Kidney Problems	Y N High/Low Blood Pressure
Y N AIDS/HIV	Y N Tuberculosis	Y N Psychiatric Problems
Y N Diabetes	Y N Anemia	Y N Ulcers
Y N Venereal Disease	Y N Cold sores/Fever blisters	Y N Hemophilia
Y N Sickle Cell Disease	Y N Bruise easily	Y N Liver Disease
Y N Tumors	Y N Nervousness	Y N Allergy to metal
Y N Osteoporosis	Y N Angina Pectoris	Y N Arteriosclerosis
Y N Mitral Valve Prolapse	Y N Artificial Heart Valve	Y N Heart Pacemaker
Y N Heart Surgery	Y N Arthritis	Y N Rheumatism
Y N Coritsone Medicine	Y N Stroke	Y N Allergy to Latex
Y N Artificial Joints	Y N Glaucoma	Y N Thyroid Problems
Y N Asthma	Y N Hay Fever	Y N Emphysema
Y N Allergies/Hives	Y N Sinus Trouble	Y N Radiation Therapy
Y N Developmentally Disabled		

Have you been treated for any other illness not listed above? ________Yes ________No

If yes, please explain:____

Do you need to be pre-medicated before dental treatment? Yes No Don't know

If yes, what medical condition do you pre-medicate? ____

Are you allergic to any of the following medications? _____ None

Y N Penicillin Y N Aspirin Y N Erythromycin Y N Codiene

Y N Dental Anesthetic Y N Sulfa Y N Other:

Doctor's Comments:

RELEASE

I understand that this information is correct to the best of my knowledge.

I authorize Dr. Simeteys to perform diagnostic procedures and treatment as may be necessary for proper dental care.

I authorize the release of any information concerning my health care, advice, and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I hereby authorize payment of insurance benefits directly to Dr. Simeteys, otherwise payable to me. I understand that my dental insurance carrier or payer of my dental benefits may pay less than the actual bill for services. I understand I am financially responsible for payments in full of all accounts. By signing this statement, I agree to be responsible for payment of services not paid, in whole or in part by my dental care payer.

I acknowledge I have received a copy of this office's Notice of Privacy Practices(HIPPA) and the Dental Materials Fact Sheet.

Patients's Signature:____Date:______

Doctor' Signature:____Date:_______