Patient Information

Patient Name: _____
Last First MI (Preferred Name)

Social Security #: _____ **Birth Date:** _____ **Sex:** Female Male

Marital Status: Married Single Child **Best way to reach you:** Email Text Message Phone

Phone (Home/Work): _____(Mobile):_____

Email: _____

Address:_____

Insurance Information If Applicable

Name of insurance provider:_____

Name of primary subscriber if not the patient:_____

Subscriber''s Birth Date: _____ ID #: _____ Group #: _____

Subscriber''s Address:_____

Subscriber's Employer Name:_____

Your relationship to subscriber:: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name
Address:_____

Name of a secondary dental insurance if applicable:_____

Whom may we thank for referring you to our practice? _____

Health Information

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

Have you ever had any of the following? Please check those that apply:

☐ Ulcers
☐ AIDS/HIV
☐ Codeine Allergy
☐ Penicillin Allergy
☐ Anemia
☐ Arthritis
☐ Artificial Joints
☐ Asthma
☐ Blood Disease
☐ Cancer
☐ Diabetes
☐ Dizziness
☐ Epilepsy
☐ Excessive Bleeding
☐ Fainting
☐ Glaucoma
☐ Growths
☐ Hay Fever
☐ Head Injuries
☐ Heart Disease
☐ Heart Murmur
☐ Hepatitis
☐ High Blood Pressure
☐ Jaundice
☐ Kidney Disease
☐ Liver Disease
☐ Mental Disorders
☐ Nervous Disorders
☐ Pacemaker
☐ Pregnancy
Due Date:
☐ Radiation Treatment
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Rheumatism
☐ Sinus Problems
☐ Stomach Problems
☐ Venereal Disease
☐ Stroke
☐ Tuberculosis
☐ Tumors
OTHER:
☐
Allergies:_____

_____

· Are you currently taking any medications (including supplements)? ☐ Yes ☐ No
If yes, please list: _____

· Have you ever had any complications following dental treatment? ☐ Yes ☐ No
If yes, please explain:_____

· Have you been admitted to a hospital or needed emergency care during the past two years?
☐ Yes ☐ No
If yes, please explain:_____

· Are you now under the care of a physician? ☐ Yes ☐ No
If yes, please explain:_____

· Physician:_____Phone:_____

· Do you have any health problems that need further clarification? ☐ Yes ☐ No
If yes, please explain:_____

Emergency contact name and number:_____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____
Patient name (printed)

_____
Signature of patient, parent or guardian Date

Cancellation Policy

Our goal is to provide quality health care to all our patients in a timely manner. No-shows, late arrivals, and cancellations inconvenience not only our providers, but our other patients as well. Please be aware of our policy regarding missed appointments.

We understand that sometimes, unexpected delays can occur, making schedule adjustments. If you need to cancel your appointment, we respectfully request at least 24 hours' notice. Patients who fail to show for their scheduled appointment, or do not notify the office within 24 hours of their scheduled appointment time shall be subject to a **"No Show/Cancellation" fee of $50**.

In the event of a true, unavoidable emergency, all or part of your cancellation fee may be applied to future services.

By signing below I certify that I have read and understand the terms and conditions of SIMPLYDENTISTRY's appointment
cancellation policy:

X_____
Patient Signature Date

Consent for Services/Financial Agreement

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care. Financial responsibility of each patient must be determined before treatment.

FINANCIAL AGREEMENT: For patients with insurance, I understand that I am financially responsible for all charges not covered by my insurance. I understand that the office agrees to bill insurance as a courtesy. I must submit information when needed and in a timely manner, to ensure that payment is made for services rendered. We will gladly submit a pretreatment estimate to your insurance for your treatment needs, however this is only an estimate and not a guarantee of payment from your insurance. I understand that I am ultimately responsible for payment of all services. Copayments and deductibles are due on the day of service. I understand it is my responsibility to let the office know if I have new dental insurance prior to dental treatment.

I understand that the fee estimate listed for dental care can only be extended for a period of six months from the date of the patient examination.

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

I have read the above conditions of treatment and payment and agree to their content.

Patient name (printed)_____

_____ Date: _____
Signature of patient, parent, guardian, or guarantor

Relationship to Patient:_____