simply dental

PATIENT INFORMATION

Patient Name: _____ Date: _____
Last First MI

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 #: _____

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 courtesy to you, we make every effort in obtaining your insurance benefits that may be available, however it is your total responsibility to know your insurance plan and coverage. Simply Dental will not be responsible for any balance(s) unpaid by insurance, regardless of the reason/circumstance. We will file insurance claims for you provided we can receive 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 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, American Express or Care Credit. 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 ($39.00) for failure to keep a scheduled appointment or for canceling an appointment without 48 hours advance notice. We cannot accept cancellations or changes in regards to any appointment through email. A phone call to an office team member is expected should you need to make a change or cancel an appointment. I understand that I will be charged a fee of $20-$30 for the duplication and/or 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 and costs of collections (30% of the unpaid balance), court costs, and/or other expenses and fees if my account(s) become delinquent. Delinquent account balances are the sole responsibility of the patient or the patient's guarantor, regardless of any divorce decree or court order regarding payment of dental bills.

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/Parent/Guardian _____ Date: _____

REFERRAL INFORMATION

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

☐ Another patient: _____ ☐ Another Doctor: _____

Other: _____

Acknowledgement of Receipt of
HIPAA
(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.

_____

Signature of Patient, Parent or Guardian Date

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

_____

_____

Patient's Signature Date

Revised 2.13.18

PATIENT DENTAL HISTORY & QUESTIONNAIRE

DATE: _____

PATIENT NAME: _____ BIRTH DATE _____

Reason for this visit: _____

Date of last dental visit: _____ What was done: _____

Previous dentist name: _____

Are your teeth sensitive to hot, cold, sweets, or biting pressure? ☐ yes ☐ no

Does food constantly get stuck between certain teeth in your mouth? ☐ yes ☐ no

Are you unhappy with the way your teeth look? ☐ yes ☐ no if yes, please explain _____

Have you ever had any teeth removed? ☐ yes ☐ no

Do your gums bleed when brushing or flossing? ☐ yes ☐ no

Do you have an unpleasant taste or odor in your mouth? ☐ yes ☐ no

How often do you brush your teeth? _____

How often do you floss your teeth? _____

Has fear of discomfort kept you from regular dental visits? ☐ yes ☐ no

Are you concerned about the finances required to return your mouth to excellent oral health? ☐ yes ☐ no

What prompted you to seek dental care at this time? _____

Are you interested in teeth whitening? ☐ yes ☐ no

On a scale from 1- 10 (1 not important, 10 extremely important) how important are your teeth to you? _____

Do you feel pain to any of your teeth? ☐ yes ☐ no

Do you have any sores or lumps in or near your mouth? ☐ yes ☐ no

Have you ever had any head, neck, or jaw injuries? ☐ yes ☐ no

In reference to your jaw – have you experienced any of the following:

☐ clicking ☐ pain (joint, ear, side of face) ☐ difficulty in opening or closing ☐ difficulty in chewing?

Do you have frequent headaches? ☐ yes ☐ no

Do you clench or grind your teeth? ☐ yes ☐ no

Do you bite your lips or cheeks? ☐ yes ☐ no

Have you noticed any loose teeth? ☐ yes ☐ no

Have you ever been informed or treated for periodontal disease (gum disease)? ☐ yes ☐ no

Is there any family history of periodontal disease? ☐ yes ☐ no

Ever worn a nightguard or other appliance? ☐ yes ☐ no

Have you ever had any difficult extractions in the past? ☐ yes ☐ no

Do you wear partials or dentures? ☐ yes ☐ no

Have you ever received oral hygiene instructions regarding the care of your teeth and gums? ☐ yes ☐ no

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN _____ **DATE** _____

MEDICAL HISTORY

DATE: _____

PATIENT NAME: _____ BIRTH DATE _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now ☐ yes ☐ no if yes, please explain _____

Name of Physician: _____ Phone Number: _____

Have you ever been hospitalized or had a major operation ☐ yes ☐ no if yes, please explain _____

Have you ever had a serious head or neck injury ☐ yes ☐ no if yes, please explain _____

Are you taking any medications or drugs ☐ yes ☐ no if yes, please explain _____

Do you take, or have you taken, oral bisphosphonates (examples: Boniva, Fosamax) ☐ yes ☐ no if yes, please explain _____

Are you on a special diet ☐ yes ☐ no if yes, please explain _____

Do you use tobacco ☐ yes ☐ no

Do you use controlled substances ☐ yes ☐ no

Women: Are you ☐ Pregnant Due date _____
☐ Trying to get pregnant? ☐ Nursing?
☐ Taking oral contraceptives? ☐ None

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics
☐ Sulfa ☐ Epinephrine ☐ Peanuts/Nuts ☐ None
☐ Other if yes, please explain: _____

Do you have, or have you had, any of the following?

☐ AIDS/HIV Positive	☐ Cold Sores/Fever Blisters	☐ Glaucoma	☐ Kidney Problems	☐ Sickle Cell Disease
☐ Alzheimer's Disease	☐ Congenital Heart Disorder	☐ Hay Fever	☐ Leukemia	☐ Sinus Trouble
☐ Anaphytaxis	☐ Convulsions	☐ Heart Attack/Failure	☐ Liver Disease	☐ Spina Bifida
☐ Anemia	☐ Cortisone Medicine	☐ Heart Murmur	☐ Low Blood Pressure	☐ Stomach/Intestinal Disease
☐ Angina	☐ Diabetes	☐ Heart Pace Maker	☐ Lung Disease	☐ Stroke
☐ Arthritis/Gout	☐ Drug Addicition	☐ Heart Trouble/Disease	☐ Mitral Valve Prolapse	☐ Swelling of Limbs
☐ Artificial Heart Valve	☐ Easily Winded	☐ Hemophilia	☐ Pain in Jaw Joints	☐ TMJ
☐ Artificial Joint	☐ Emphysema	☐ Hepatitis A	☐ Parathyroid Disease	☐ Thyroid Disease
☐ Asthma	☐ Epilepsy or Seizures	☐ Hepatitis B or C	☐ Psychiatric Care	☐ Tonsillitis
☐ Blood Disease	☐ Excessive Bleeding	☐ Herpes	☐ Radiation Treatments	☐ Tuberculosis
☐ Blood Transfusion	☐ Excessive Thirst	☐ High Blood Pressure	☐ Recent Weight Gain/Loss	☐ Tumors or Growths
☐ Breathing Problem	☐ Fainting Spells/Dizziness	☐ High Cholesterol	☐ Renal Dialysis	☐ Ulcers
☐ Bruise Easy	☐ Frequent Cough	☐ Hives or Rash	☐ Rheumatic fever	☐ Venereal Disease
☐ Cancer	☐ Frequent Diarrhea	☐ Hyperglycemia	☐ Rheumatoid Arthritis	☐ Yellow Jaundice
☐ Chemotheraphy	☐ Frequent Headaches	☐ Hypoglycemia	☐ Scarlet Fever	
☐ Chest Pain	☐ Genital Herpes	☐ Irregular Heartbeat	☐ Shingles	

Have you ever had any serious illness not listed above? ☐ yes ☐ no if yes, please explain _____

Is a pre-med needed for dental appointments? ☐ yes ☐ no if yes, reason for medication _____

Medication/Dosage: _____

Pharmacy Name and Phone Number: _____

List of Current Medications: ☐ No Mediciations

Name of Medication/Dosage/Frequency	Condition

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SIGNATURE OF PATIENT, PARENT, OR GUARDIAN _____ **DATE** _____