angela l.simpson dds
FAMILY AND COSMETIC DENTISTRY

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Patient Information

Patient Name_____ Date:_____
Last First MI

❑ Male ❑ Female ❑ Married ❑ Single ❑ Child

Social Security #:_____ Birth Date:_____ Email Address:_____

Phone (Home):_____(Work):_____Ext.: _____Mobile:_____

Best number to contact for appointment reminder _____

Address:_____
Street Apartment #

_____
City State Zip Code

Health Information

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

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

❑ AIDS
❑ Allergies _____
_____
❑ Allergic to Latex
❑ Anemia
❑ Anxiety
❑ Arthritis
❑ Artificial Joints
❑ Asthma
❑ Cancer
❑ Diabetes
❑ Epilepsy
❑ Excessive Bleeding
❑ Eye Surgery
❑ Glaucoma
❑ Heart Disease
❑ Heart Murmur
❑ Hepatitis
❑ High Blood Pressure
❑ Mental Disorders
❑ Mitral Valve Prolapse
❑ Pacemaker
❑ Pregnancy (Currently)
Due Date:_____
❑ Radiation Treatment
❑ Respiratory Problems
❑ Rheumatic Fever
❑ Tobacco Use
❑ Tuberculosis
❑ Ulcers
❑ Are you allergic to any medications?
_____
❑ Need for Premedication
❑ Are you taking any medications?_____
_____
_____
_____
_____
❑ History or Family History of Gum Disease

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:_____

Name of Physician:_____Phone: _____

Do you have any health problems that need further classification? ❑ Yes ❑ No
If yes, please explain:_____

Do you ever feel self-conscious about your breath? ❑ Yes ❑ No

Would you like teeth to be whiter? ❑ Yes ❑ No

Is there anything about your smile that you wish you could change? ❑ Yes ❑ No

Do you have any dental fears or concerns? ❑ Yes ❑ No

What can we do to make you the most comfortable? _____

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

_____ Date:_____
Signature of patient, parent or guardian

_____ Date:_____
Signature of Doctor

Referral Information

Whom may we thank for referring you to our practice? ❑ Another patient ❑ Dental Office

❑ Yellow Pages ❑ Work ❑ Other_____

Name of person referring you to our practice:_____

Employment Information

The following is for ❑ the patient ❑ the person responsible for payment

Employer Name:_____ Occupation:_____

Address:_____

Street City State Zip Code

Insurance Information

Primary

Name of Insured_____ Is insured a patient? ❑ Yes ❑ No

Last First MI

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

Insured's Address:_____

Street City State Zip Code

Insured's Employer Name:_____

Address:_____

Street City State Zip Code

Patient's relationship to insured: ❑ Self ❑ Spouse ❑ Child ❑ Other_____

Insurance Plan Name and Address: _____

Secondary

Name of Insured_____ Is insured a patient? ❑ Yes ❑ No

Last First MI

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

Insured's Address:_____

Street City State Zip Code

Insured's Employer Name:_____

Address:_____

Street City State Zip Code

Patient's relationship to insured: ❑ Self ❑ Spouse ❑ Child ❑ Other_____

Insurance Plan Name and Address: _____

Consent for Services

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 and financial responsibility on the part of each patient must be determined before treatment.

All dental services, including emergency dental services and dental services performed without pervious financial arrangements must be paid for at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the client and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render service on the assumption that our charges will be paid by an insurance company.

A service charge of 1 1/2% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 90 days, unless previously written financial arrangements are satisfied.

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

I understand that the practice reserves the right to charge a cancellation fee of $45.00 for any appointment broken without a 24 hour notice.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said service to said Doctor, or his/her assignee, at the time said services are rendered, I further agree that the reasonable value of said services shall be billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term of condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

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.

_____ Date: _____ Relationship to Patient: _____

Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____

Signature of guarantor of payment / responsible party