FAMILY DENTAL CARE

EUGENE SIMONS, D.D.S., P.C.
331 WILLIS AVENUE • MINEOLA, N.Y. 11501
(516) 746-5050

Dear Patient,
It is a pleasure to welcome you to our practice. We look forward to providing you with quality dental care.

Name _____ Marital Status _____

Address _____ Soc Sec # _____

_____ Telephone _____

Name of Physician _____ Phone _____

Address _____ Cell _____

Date of Last Visit _____ E-mail _____

Reason _____ Referred by _____

Birthdate _____

The guarantor(s) shall be fully responsible and liable for the entire amount of any and all charges for service rendered to the patient which have not been paid by and other source.
As a courtesy and convenience to the guarantor(s), Eugene Simons, D.D.S., P.C. will submit application for payment to any third party payor, but this will in no way limit the right of Eugene Simons, D.D.S., P.C. to demand full payment by the guarantor(s) for the care rendered to the patient.
The guarantor(s) agree that the failure of any third payor to make payments, for whatever reason, will in no way prevent Eugene Simons, D.D.S., P.C. from enforcing this agreement, and any costs involved in satisfying debts.

Primary (Patient's) Insurance Name _____

Group # _____ Social Security # ___/___/___

Contract # _____ Union Plan (Local #) _____

Employer's Name _____

Employer's Address _____

Employer's Telephone _____

Secondary (Spouses) Insurance Name _____

Group # _____ Social Security # ___/___/___

Contract # _____ Union Plan (Local #) _____

Employer's Name _____

Employer's Address _____

Employer's Telephone _____

Father's Insurance Company _____

Mother's Insurance Company _____

MEDICAL HISTORY

The following information is essential for this office to provide dental care in a manner that is compatible with your general health. Your cooperation in providing accurate information is necessary to meet your dental needs safely and efficiently. Incorrect information can be dangerous to your health.

What is you present health? Good ☐ Questionable ☐ Poor ☐
Have you been under medical treatment recently? Yes ☐ No ☐
List medications you are presently taking

_____ _____

_____ _____

Drug Allergies? Please list

_____ _____

_____ _____

Have you ever been informed that you have, or have had any of the following?

Y	N		Y	N	
☐	☐	Heart trouble/heart attack	☐	☐	Problem with immune system
☐	☐	Congenital heart lesions	☐	☐	A stroke
☐	☐	Rheumatic heart disease/fever	☐	☐	Hepatitis
☐	☐	High blood pressure/Low	☐	☐	Liver disease
☐	☐	Heart Murmur	☐	☐	Jaundice
☐	☐	Ulcers/Stomach disorders	☐	☐	Anemia
☐	☐	Palpitations/Chest pains	☐	☐	Bronchitis
☐	☐	Shortness of breath/swollen ankles	☐	☐	Leukemia
☐	☐	Bleeding/Blood clotting problems	☐	☐	Asthma
☐	☐	Intestinal Disorders	☐	☐	Kidney disease
☐	☐	Tuberculosis	☐	☐	Venereal disease
☐	☐	Chronic cough/sinus trouble	☐	☐	Diabetes
☐	☐	Allergies to drugs	☐	☐	Thyroid disorder
☐	☐	Neurological disorders	☐	☐	Glaucoma
☐	☐	Epilepsy/undiagnosed seizures	☐	☐	Arthritis
☐	☐	Emotional problems	☐	☐	HIV positive

☐ ☐ Are you pregnant? Are you nursing? Yes ☐ No ☐
☐ ☐ Are you presently on, or recently been on cortisone therapy?
☐ ☐ Are you presently taking anti-coagulant (blood thinning) drug?
☐ ☐ Have you ever had cardiac (heart) surgery?
☐ ☐ Are you wearing a pace-maker?
☐ ☐ Are you wearing any other internal prostheses?
☐ ☐ Have you ever received chemo-therapy or radiation therapy?
☐ ☐ Have you ever had adverse reactions to local/general anesthetics?
☐ ☐ Do you have any health problem or condition not covered above that you feel the doctor should be aware of before commencing treatment?

. . . . . .

*NOTE: A change in your health status should be reported to the office at the earliest possible time.
In order to be fair to you and other patients, we require 24 hours notice of a cancelled appointment to avoid incurring a $25.00 charge.

To the best of my knowledge, the foregoing questions have been accurately answered.
PERMISSION TO RELEASE HEALTH INFORMATION.

I hereby grant the right to the dentist to release health information obtained from me, and information about my dental treatment to third party payors, and/or other health practitioners.

Person completing form (sign): _____

Date: _____ Print name: _____

If other than patient, indicate relationship: _____

Emergency Contact and Number: _____