Simply DENTISTRY

Health Information

Simply Dentistry Takes your oral health very seriously. But before we start your treatment, we need some brief information on your medical history which may effect your treatment. all information is confidential.

Patient's Name:_____ Date of Birth:_____

Reason for today's visit? _____ Work Related Injury? **Yes No**

Physician's Name & Phone #:_____ Last Physical Exam date:_____ Height:_____Weight:_____

Date of last Dental Visit: _____ Date of last Dental x-rays:_____ Date of last cleaning:_____

Have you ever been treated for periodontal (gum) disease? **Yes No**

Ever had Novocaine or other local anesthetic? **Yes No** Are you interested in tooth whitening? **Yes No**

If wearing dentures, age of dentures:_____ Are you interested in new dentures? **Yes No**

Are you taking or have taken any STEROID/CORTISONE treatment in the last 2 years? **Yes No**

Are you taking or have taken Oral Bisphosphonates?[e.g.fOSAMAX, ACTONEL, BONIVA, OR IV Bisphosphonates, (e.g. ZOMETA, AREDIA)] **Yes No** Taken for how long?_____

Have you taken antibiotics prior to dental procedures in the past? **Yes No**

Have you ever had an adverse reaction or become ill after taking penicillin, aspirin, codeine, local anesthetics, latex, metals or any other medication? **Yes No**

List any Medication you are ALLERGIC to: 1._____ 2._____ 3._____

List any Medication you are TAKING including non-prescription drugs and herbal/vitamins:

1._____ 2._____ 3._____ 4._____

5._____ 6._____ 7._____ 8._____

Do you have a history of:	Y	N		Y	N		Y	N		Y	N
Rheumatic Fever			Anemia			Sinus Problems			Epilepsy or Seizures		
Heart Murmur			Blood Transfusion			Allergies or Hives			Fainting or Dizzy Spells		
Mitral Valve Prolapse			HIV Positive /AIDS			Asthma			Arthritis		
Diabetes			Venereal Disease			Lung Disease			Ulcers or Stomach Problems		
High Blood Pressure			Hepatitis(Type)			Breathing Problems			Any Type of Transplant		
Low Blood Pressure			Excessive bleeding			Use of tobacco Products					
Stroke			Liver Disease			Alcoholism			Any type of Implant		
Heart problems			Kidney Disease			Drug Addiction					
Pace Maker			Dialysis			Psychiatric Treatment			Any Artificial		
Heart Surgery			Cancer			Pain in your jaw (TMJ)			Hip, Knee, or other Joint		
Aspirin			Chemotherapy			Teeth Grinding/Clenching			other Disease or Illness		
Anticoagulant Therapy			Radiation Treatment			Mouth sores/ growths					
Thyroid Disease			Tuberculosis (TB)			Latex Allergy					

Women Patients only:	Y	N		Y	N
Is there a possibility of Pregnancy?			Are You Nursing?		
Estimated Delivery Date: / /			Are you taking any Birth Control Prescription?		

Note: Antibiotics (such as Penicillin) may alter the effectiveness of birth control pills. Consult your physician/ gynecologist for assistance regarding additional methods of birth control.

I certify that I have read and understand the above questions and acknowledge that questions have been answered to the best of my knowledge. I here-by give my consent to the dentist to perform an examination and diagnose my condition. I also give my consent for any preventive or basic restorative procedures which may be necessary. I understand that this consent will remain in effect until treatment is terminated either by me or the dentist.

Patients Signature_____ Date_____ Dr's/ medical History Review _____ Date_____

Patients Signature_____ Date_____ Dr's/ medical History Review _____ Date_____

Simply DENTISTRY

Patient Information

Please Print
Circle one: Dr/Mr/Mrs/Ms/Miss
First:_____ Middle:_____
Last:_____ Jr/Sr:_____
Street:_____ City:_____
State:_____ Zip:_____
Home Phone:_____ Work Phone:_____
Cell Phone:_____ May we Text you? Yes No
Email Address:_____ May we Contact you by email? Yes No
Patient Social Security Number:_____ Patient Date of Birth:_____ Sex: M F
Emergency Contact:_____ Phone :_____
How did you Hear about **Simply Dentistry**? _____

Insurance Information
Do you have Dental Insurance? Yes No Do you have Second Dental Insurance? Yes No

Primary Insured		**Secondary Insured**	
Subscriber Name		Subscriber Name	
Subscriber SSN		Subscriber SSN	
Date of Birth		Date of Birth	
Relationship to Subscriber		Relationship to Subscriber	
Employer Name		Employer Name	
Employer Phone		Employer Phone	
Insurance Company		Insurance Company	
Insurance Group#		Insurance Group#	
Insurance Phone #		Insurance Phone #	

- Please Present Your Insurance Card To be Photocopied

Authorization for Release of Health Records To External Parties

I authorize the disclosure of information from my treatment records to:
Name of Recipient:_____ Relationship to Patient:_____

I give authorization to disclose the following information:
____ All Treatment information ____Information specifically related to these dates

Starting Date:_____ End Date:_____
I understand that I may withdraw or revoke my permission at any time. I may revoke this authorization by notifying **Simply Dentistry** in writing.
Signature of Patient (or Patient Representative) _____ Date:_____
Print Name of Patient (or Patient Representative) _____ Date:_____

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Patient Signature Page

Notice of Privacy Practices (must be signed by ALL new patients).
By signing below, I acknowledge that I have read Simply Dentistry's Notice of Privacy Practices, as mandated by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

Signature:_____Date:_____
(If patient is a minor or disabled, the Parent, Guardian or Attorney-in-Fact must sign above and complete the Responsible Party section below)

Payment,Insurance, and Financial Arrangement Policies (Must be signed by ALL new patients).
By signing below, I agree to the terms of the "Simply Dentistry Patient Acknowledgements, Agreements, and Authorizations" documents.

Signature:_____ Date:_____
(If patient is a minor or disabled, the Parent, Guardian or Attorney-in-Fact must sign above and complete the Responsible Party section below)

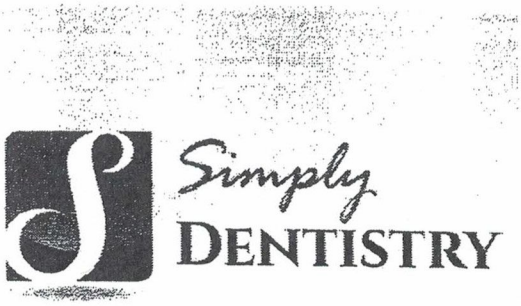
Release of Information to Insurers and Assignment of Benefits (Must be signed by all new patients with insurance and those who expect to obtain insurance).
To the extent permitted by law, I consent to Simply Dentistry's use and disclosure of my Protected Health Information to carry out payment activities in connection with insurance claim. This information will be used exclusively for the purpose of evaluating and administering claims for benefits. I further authorize and direct payment to Simply Dentistry of the dental benefits otherwise payable to me.

Signature:_____ Date:_____
(If patient is a minor or disabled, the Parent, Guardian or Attorney-in-Fact must sign above and complete the Responsible Party section below)

Responsible Party (If patient is under 18 or disabled)

Circle One: Dr/Mr/Mrs/Ms/Miss

First:_____ Middle:_____ Last:_____ Jr/Sr:____
Street:_____ City:_____ State:_____ Zip:_____
Home Phone:_____ Work Phone:_____ Cell Phone:_____
Patients SSN:_____ Patients Date of Birth:____/____/____ Sex: M F
Signature:_____ Date:_____



5800 N. Lilley Rd
Canton, MIchigan 48187
Phone: 734-407-7900
Fax: 734-943-6373

Dear Patient :

Thank you for choosing our practice for your dental care. We are committed to service and your dental needs.

Please understand that your scheduled appointment time is reserved especially for you. If you need to miss an appointment, we require at least 24 hour notice. This is necessary to allow sufficient time for another patient to schedule an appointment.

In the event of a late notice or missed appointment, there will be a $40 charge billed to you. To avoid this charge, kindly give us at least 24 hour notice. Thank you for cooperating with us.

Print Patient Name _____ Date of Birth

Patient or Guardian Signature _____ Date