Michael E. Simony D.D.S., P.C.
41700 Hayes Rd. Suite D
Clinton Twp., Mi. 48038
586-263—9300
www.drsimony.com

Welcome

All About You!

Patient **Today's Date:** _____/_____/______

Name: ___________________________
Last First Mi

Prefered Name: ___________________________

__ male __female Birthdate: ___/___/____

Age: ________ SS#:______________________

Driver's License #: _______________________

Mailing Address: ________________________

____
City State Zip

Home Phone#: (____)______________________

Work Phone #:(____)______________Ext:______

Cell Phone #:(____)______________________

E-Mail Address: _________________________

Preferred number to call to confirm: ___home ___work ___ cell

Status:__Minor__Single__Married__Divorced__other

Spouse's Name: ___________________________

Do you have children? __Yes __No How Many? _______

Referred By: ____________________________

Employer: _______________ How long? ______

Account Information

Person ultimately responsible for the account

Name: ______________________________

Relation: ____________________________

Billing Address: _______________________

____
City State Zip

SS#: _______________________________

Driver's License #: ____________________

Work Phone #:(____)______________Ext____

Payments and co-payments are due at the time services are rendered

Insurance

Primary Dental Insurance

Ins. Name: ________________________

Address: __________________________

____
City State zip

Phone #: (____) __________

Insured's ID#: _______________________

Group # (plan, local, or policy #): _________

Insured's name: _____________________

Relation: _______ Birthdate: _/___/____

Employer: __________________________

Secondary Dental Insurance

Ins. Name: ________________________

Address: __________________________

____
City State zip

Phone #: (____) __________

Insured's ID#: _______________________

Group # (plan, local, or policy #): _________

Insured's name: _____________________

Relation: _______ Birthdate: _/___/____

Employer: __________________________

For Emergency

Whom should we contact in the event of an emergency?

Name: ___________________________

Relation: _________________________

Home Phone#: (____)_______________

Work Phone #:(____)___________Ext:___

Cell Phone #:(____)________________

Medical Doctor? ____________________

Doctor's Phone#:(____)_____________

Please continue on reverse side

Dental Information

Reason for your visit today? ____

Are you in pain? __no __yes How Long? ____

Please indicate any of the following problems:

__discomfort, Clicking or popping in jaw __lost/broken filling(s) __stained teeth
__red, swollen or bleeding gums __teeth grinding __locking jaw
__sensitive tooth, teeth or gums __ringing in ears __bad breath
__blisters/sores in or around mouth __broken/chipped tooth
__other: ____

Previous dentist: ______________________________ (____) __________________________
Name phone #

Last dental exam: ___/___/___ last x-rays: ___/___/___ times a day you brush//floss? ___/___

What type of tooth brush bristles do you use? __soft __medium __hard

Rate your smile 1-10? ______ (with 10 being the best)

Medical History

What medications are you taking? __nerve pills __pain killers (including aspirin) __muscle relaxers __ stimulants __ blood thinners __tranquilizers __insulin __meds for osteoporosis __others (please list):______________________

Have you ever taken : bisphosphonates (ex. Aredia/fosamax) __yes __no Phen-fen/Redux __yes __no

Do you require pre-medication? __yes __ no __don't know

Do you have or have you had any of the following diseases, medical conditions or procedures?

Y N heart attack/ stroke	Y N thyroid problems	Y N cancer/tumors	Y N cosmetic surgery
Y N heart surgery/pacemaker	Y N kidney problems	Y N shingles	Y N x-ray or cobalt treatment
Y N heart murmur	Y N liver problems	Y N hepatitis	Y N chemotherapy
Y N rheumatic fever	Y N respiratory problems	Y N HIV+/ AIDS/ARC	Y N asthma
Y N mitral valve prolapsed	Y N sinus problems	Y N arthritis/ rheumatism	Y N difficulty breathing
Y N Artificial valves	Y N stomach problems/ulcers	Y N artificial bones/joints	Y N diabetes/hypoglycemia
Y N heart disease	Y N psychiatric problems	Y N emphysema	Y N leukemia
Y N congenital heart defect	Y N venereal disease	Y N fainting/seizures/epilepsy	Y N anemia
Y N cheat pains	Y N alcohol/drug abuse	Y N severe/frequent headaches	Y N high/low blood pressure
Y N scarlet fever	Y N tuberculosis TB	Y N frequent neck pain	Y N bleeding problems
Y N nervousness	Y N jaw problems TMJ/TMD	Y N back problems	Y N glaucoma

Please list any other surgeries or medical conditions you have or ever had: ______________________________________
____

Are you allergic to any of the following? __latex __penicillin/amoxicillin __ tetracycline __aspirin __ dental anesthetics __foods

Any other allergies? ____

Do you use tobacco? __yes __no /how used? ___________how much? ____ how long? ___

Please rate your general health from 1-10: ______ Do you wear contact lenses? __yes __no For Women:

Are you taking birth control pills? ____ How many children have you had? ____ Are you pregnant? ___Are you nursing? ___

- **We invite you to discuss with us any questions regarding our services. Thw best Dental health services are based on a friendly, mutual understanding between provider and patient.**
- **Our policy requires payment in full for all services rendered at the time of your visit. If account is not paid within 90 days of the date of service and no arrangements have been made with the business manager, you will be responsible for interest charges, late fees, legal fees, collections agency fees, and any other expenses incurred in collecting your account.**
- **I authorize the staff to perform any mecessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.**
- **I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.**

Signature : _______________________________________ Date: ____/____/_____