SIMON FAMILY DENTAL
IMPLANT • COSMETIC • GENERAL

7925 S. Broadway Ave, Suite 1100 Tyler TX 75703 (903)213-9799

Patient Information

Name:_____ Preferred Name:_____ Sex: M or F

Mailing Address:_____

City:_____ State:_____ Zip_____ Employer_____

Date of Birth:_____ SSN:_____ Email address_____

Home Phone:_____ Cell Phone:_____ Work Phone:_____

Guardian/Spouse or Person Responsible for Account

Name:_____ Relationship:_____

Mailing Address:_____

City:_____ State:_____ Zip_____ Employer_____

Date of Birth:_____ SSN:_____

Home Phone:_____ Cell Phone:_____ Work Phone:_____

Emergency Contact:_____ **Relationship**_____
Cell Phone:_____

Dental Insurance

Primary Insurance

Insurance Co:_____
ID#:_____ Group #: _____
Phone #:_____
Employer:_____
Policy Holder:_____
DOB:_____SSN_____

Secondary Insurance

Insurance Co:_____
ID#:_____ Group #:_____
Phone #_____
Employer:_____
Policy Holder:_____
DOB_____SSN:_____

Medical History

Name:_____Date of Birth:_____

Allergies/Reactions **_____ I have no medication allergies**

Medications/Condition **____ I am not taking any medications**
(Please list all prescriptions and over the counter medications, aspirin/blood thinners, or provide list to scan)

Have you taken any medications for Osteoporosis? (Yes or No)
(These medications can stay in your system for 10 years or more.)
_____Actonel _____Aredia _____Boniva _____Fosomax___ Xometa or Other_____

Women: Are you ***pregnant*** or ***nursing*** (how many months)?_____

Any ***surgeries*** (when)?_____

Has your doctor recommended ***antibiotics*** before dental care?_____

Do you use tobacco(if so how much/how long)?_____

Do you have or ever had any of the conditions listed below?(Check all that apply)

_____ Allergies	_____Cold sores	____Kidney disease
_____ Anemia	_____Diabetes	_____Leukemia
_____ Arthritis/Rheumatism	_____Dizziness/Fainting	_____Lupus
_____ Artificial Heart Valve	_____Emphysema	_____Osteoporosis/Osteopenia
_____ Artificial joints	_____Epilepsy/Seizures	_____Psychiatric Disorders
_____ Asthma	_____Glaucoma	_____Rheumatic Fever
_____ Back/neck pain	_____Growths/Tumors	_____STDs/HPV
_____ Bleeding problems	_____Head Injury	_____Shingles
_____ Blood pressure High/Low	_____ Headaches	_____Sinus Problems
_____ Breathing Problems	_____ Heart Murmur	_____Stomach Problems/ulcers
_____ Cancer	_____ Heart Attack/Disease	_____Stroke
_____ Chemotherapy/Radiation Therapy	_____Heart Pacemaker	_____Swollen Ankles
_____Chest Pains	_____Hepatitis/Liver Disease	_____Thyroid Disease
_____ Cholesterol High/Low	_____Herpes	_____Tuberculosis
_____ Chronic Cough	_____HIV+ AIDS	_____Other(please explain)

I have answered all questions to the best of my knowledge. I will not hold Simon Family Dental responsible for any errors. You have my consent to ask my respective health care provider. I will notify the doctor of any changes in my health or medications

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Patient/Guardian Signature **Date**

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No Show and Cancellation Policy

We recognize that everyone's time is valuable; patients and doctors alike. Failure to appear to a scheduled appointment not only compromises your health, but inconveniences other patients who may have requested an office visit during your scheduled appointment time. We also understand that emergencies happen and will do our best to accommodate you in any way that we can in case of such an emergency.

Cancellation made in less than 24 hours notice will be documented in your chart as a missed or canceled appointment. Patients with multiple last minute cancellation or missed appointments will be required to pay a $75.00 deposit in order to reschedule a hygiene appointment and 100% of their patient portion to rescheduled restorative appointments with the doctor. These deposits can be taken over the phone upon scheduling and will be applied on your account to use toward future treatment. A $75.00 fee will be withheld from your deposit if you cancel or no show that appointment within 24 hours of your scheduled appointment time.

By signing here, we enter into a relationship of mutual respect for your time and ours. You are also acknowledging that you have thoroughly read and understand the no show/cancellation policy.

Signature Printed Name Date

*** Cancellations the day before will count as a missed/canceled appointment***

Financial Policy

Welcome to our practice and thank you for choosing us as your dental care provider. Our office is committed to providing you with the best possible care using the material, technology and tools necessary to recommend personalized treatment based upon your dental needs, not based on insurance coverage. This financial policy is intended to facilitate our ability to continue to provide you with excellent dental services.

(1) Payment in full is expected at the time of service
(2) We accept cash, credit, or offer monthly payment plans via our preferred third party vendors, including Care Credit and Sunbit
(3) Patients under the age of 18 must have an adult (guardian) above the age of 21 accompany them, and the guardian is responsible for the full payment
(4) For unaccompanied minors, non-emergency treatment will be denied unless prior financial arrangements have been made.

Each of the following is a statement of our financial policy, which is required to be read, verified by initialing each statement, and signed prior to any treatment. Please initial below in agreement to the following statements before signing below:

_____I understand that it is my responsibility to provide accurate and up to date dental insurance information.

_____I understand that payment is due at the time of services rendered and I assume full responsibility for the charges incurred, including anything not covered by my insurance provider.

_____I understand that the estimate given is not guaranteed to be the exact amount since benefits cannot be fully determined until the insurance claim is filed. Your insurance is billed as a courtesy to you and although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and you agree to pay any portion of the charges not covered by your insurance.

_____I understand that certain procedures are not considered a covered procedure benefit under all dental insurance plans and as such, your insurance will not pay for these services. I understand I will be responsible in full for the cost of non-covered procedures.

_____I understand that in the event of a returned check, a $50 returned check fee will be assessed to my account.

_____I understand that if I do not make payment arrangements on any patient portion of my balance my account will be sent to collections and accrue a collection fee totaling up to 50% of the remaining balance on the account at the time of default.

_____I understand that if this account goes into default, I will be responsible for all court costs, attorney fees, and any other associated fees.

_____I understand that all prior balances (excluding insurance claims pending) will need to be paid in full before subsequent services are rendered.

_____I understand in certain circumstances, insurance companies may send payment directly to you. In such cases, you agree to endorse and send the check to our dental office. If you deposit the check from the insurance company, you agree to send a personal check for the equivalent amount to our office within 10 days of the deposit.

Authorization to release information

_____I hereby authorize Simon Family Dental to: (1) Release any information necessary to the insurance carrier regarding my care and treatment, (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature and this form to be used to process insurance claims on my behalf until revoked by me in writing.

I have read the above Financial Policy. I understand and agree to the terms stated above.

_____	_____	_____
Signature of patient	**Printed Name**	**Date**

HIPAA

Right to revoke: You will have the right to revoke this consent at any time by giving us written notice of your revocation submitted to the contact person listed above. Please understand that revocation of this consent will not affect any action we took in reliance on this consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this consent

Please print name
I, _____, have had full opportunity to read and consider the contents of this consent form and your notice of privacy practices. I understand that by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations

Signature: **Date:**

If this consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name_____.

Relationship to Patient _____.

You are entitled to a copy of this consent after you sign it.

I give Simon Family Dental permission to share my personal information with my Dental Insurance Company and the following people:

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

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New Patient Questionnaire

1. **What is your preferred pharmacy**

2. **Is there anything about your smile that bothers you or that you would like to change?**

3. **Are you interested in a brighter, whiter smile?** **YES** **NO**

4. **Are you interested in straightening your teeth?** **YES** **NO**

5. **Do you clench or grind your teeth?** **YES** **NO**

6. **Experience jaw joint pain?** **YES** **NO**

7. **Is there anything else you would like to talk about with your teeth?**

How did you hear about our office?