



THE GROVE CITY
CENTER FOR DENTISTRY

BRYAN J. SIMONE, D.D.S.
KYLE J. LOWE, D.D.S.

New Patient Form

Chart#: _____
For office use only

New Patient Information

Patient Name: Last First MI

Birthdate: ____ - ____ - ____ SS#: ____ - ____ - ____ Gender: Male Female

Family Status: Married Single Child Other : _____

Email Address:
By including your email address, you are signing up to receive appointment reminders, statements, payment confirmation and other patient information from our practice. We will protect your privacy! We promise to keep your information confidential.

Phone: Home Work Cellular

What is the best number to reach you? Home Work Cellular

Address:
 City State Zip

Preferred Appointment Times:
 Mon Tue Wed Thur Fri Morning Afternoon Evening Anytime

Who may we thank for referring you to our practice?
 Dental Office Yellow Pages Internet Newspaper Other: _____
 School Work Family Member Friend

Name of person, office, or other source referring you to our practice:

Employer Name: Phone:

Employer Address:
 City State Zip

Spouse or Responsible Party Information

Patient's Relationship to Insured: Self Spouse Child Other: _____

Please complete the information below if the responsible party information is different from the New Patient Information Form:

Insured's Name: Last First MI Birthdate: - -

SS#: - - Gender: Male Female

Phone: Home Work Cellular

What is the best number to reach the responsible party? Home Work Cellular

Address:
 City State Zip

Primary Dental Insurance Information

Insured's Name: Last First MI Birthdate: - -

SS#: - - Gender: Male Female

Insured's Employer Name:

Employer Address:
 City State Zip

Insurance Plan Name:

Plan ID#: Group#:

Insurance Address:
 City State Zip

Secondary Dental Insurance Information

Insured's Name: Last First MI Birthdate: - -

SS#: - - Gender: Male Female

Insured's Employer Name:

Employer Address:

City State Zip

Insurance Plan Name:

Plan ID#: Group#:

Insurance Address:

City State Zip

Consent for Services

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or and dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed unless other arrangements are made.

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

I understand that any fee estimate for this dental care can only be extended for a period of 120 days from the date of the patient examination.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I 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 to discuss this statement or my treatment.

I have read the above conditions of treatment and payment and agree to their content.

Signature: Date:

Relationship to Patient:



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Medical & Dental History Form

Please take a moment to let us know about your medical and dental history to help us ensure the quality of your care is the very best it can be.

Patient Name: Last First MI

Would you consider yourself to be in fairly good health? Yes No

Within the past year, have there been any changes in your general health? Yes No

What is the date (or approximate date) of your last medical exam?

List your Primary Care Physician's name, address and phone number:

Name: Phone:

Address:

City State Zip

Please answer the following:

- Have you ever had complications following dental treatment? Yes No
- Are you currently under the care of a physician due to a specific condition? Yes No
- Have you been hospitalized within the last 5 years due to surgery or illness? Yes No
- Are you currently taking any prescription or non-prescription medications? Yes No
- Do you use tobacco (smoking or chewing)? Yes No
- Do you require the use of corrective lenses (contacts or glasses)? Yes No
- Do you have any other conditions, diseases, etc., not listed above that we should be aware of? Yes No

In any of the previous questions are marked, please explain:

List all medications you are currently taking:

WOMEN ONLY: Are you pregnant? Yes No If yes, what is your due date? _____

Please indicate if you have experienced any of the following:

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Growths | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Taking Coumadin |
| <input type="checkbox"/> Amoxicillin Allergy | <input type="checkbox"/> Head Injuries | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Tetracycline Allergy |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Aspirin Allergy | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> No Epinephrine | <input type="checkbox"/> Tobacco Use |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Novocain Allergy | <input type="checkbox"/> TMJ |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Blood Thinner | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Penicillin Allergy | <input type="checkbox"/> Venereal/HPV Disease |
| <input type="checkbox"/> Codeine Allergy | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Zythromax Allergy |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> Venereal/HPV Disease |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Artificial Joints: Where _____ |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Seasonal Allergies | <input type="checkbox"/> When: _____ |
| <input type="checkbox"/> Erythromycin Allergy | <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Seizures | Cancer: Where _____ |
| <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Sinus Problems | When: _____ |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Latex Allergy | <input type="checkbox"/> Stroke | |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Taking Fasomax | |

Do you have any other health issues or allergies?

What is the reason for your dental visit today?

When was your last visit to the dentist?

What treatments were performed at your last visit?

Prior dentist's name address and phone number:

Name: Phone:

Address:

City State Zip

How frequently do you brush your teeth? 3(+) a day Twice a day Once a day Weekly Seldom

How frequently do you floss your teeth? 1 (+) a day 2-6 weekly 1-6 monthly Seldom Never

Please answer the following:

- | | | |
|--|------------------------------|-----------------------------|
| Do you your gums bleed when you brush or floss? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do your teeth experience sensitivity to cold or hot temperature? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Are any of your teeth currently causing pain? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you grind your teeth (either consciously or during sleep)? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Are any of your teeth loose, or are you concerned about any teeth loosening? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you currently have any dental implants, dentures or partials? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

In any of the previous questions are marked, please explain:

If you could change anything about your mouth, teeth or smile, what would it be?

To the best of my knowledge, all of the preceding information is true and correct. If I ever have a change in my health, will inform the office at my next dental appointment without fail.

Authorization

I hereby certify that I have read and understand previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health.

I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate.

I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent (s) to third-party insurance carriers, payors, and/or healthcare practitioners. I authorize the payment from my insurance carrier to submit payment directly to the dentist or dental practice to be applied directly to any outstanding balance on my account.

I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance, and I may be billed for this remaining balance. I consent and agree to be financially responsible for payment of all services rendered on my behalf of my dependents (if any).

Signature of patient, parent or guardian:

Signature:

Date:

Relationship to Patient: