C. GARY SIMMONS, D.D.S.

PATIENT INFORMATION

Patient Name _____ Birth Date _____

Address _____ Home Phone _____
Street

_____ Work Phone_____
City Zip code

E-mail _____ Cell Phone _____

Employer _____ SSN _____

How do you prefer to be contacted? (please circle) HOME WORK CELL EMAIL

RESPONSIBLE PARTY INFORMATION

Patient's Status (please circle) MINOR SINGLE MARRIED

Responsible Party _____ Relationship _____

Contact Phone for Responsible Party _____

Whom may we thank for referring you? _____ Relationship _____

INSURANCE INFORMATION (Please present insurance card)

Name of Insured _____ Relationship_____
to Patient

Date of Birth _____ Employee's SSN _____

Name of Employer _____ Employee's ID# _____

Our office will file your insurance and assist you in receiving the benefits you deserve. Payment for services rendered by Dr. Simmons is the responsibility of the patient regardless of insurance coverage.

I understand that I am responsible for payment of dental services received in this office.

Signature _____ Date_____

Patient Name _____

** Please advise our office if you have **ever** had pins placed in a joint or a joint replacement, heart valve replacement, shunt or stint (placed within the past 6 months) or pacemaker (placed within the past 6 months). You will be asked to take antibiotics prior to dental treatment per recommendation of the American Association of Orthopedic Surgeons and the American Heart Association. **

Family Physician _____ Phone _____

Specialist (if applicable) _____ Specialty _____ Phone _____

Pharmacy _____ Phone _____

Emergency Contact Name _____ Phone _____

1. Have you been hospitalized for any surgery or illness in the past 5 years? YES NO
   If so, please explain: _____
2. Are you taking any prescription medications, over-the-counter drugs or vitamins? YES NO
   Please list: _____
   _____
3. Do you take **prescription** blood thinners? Specify: _____ YES NO
4. Do you use tobacco? YES NO
5. Are you taking or scheduled to take prescription medication (i.e. Fosamax, Actonel) for osteoporosis or Paget's Disease? YES NO
6. Are you allergic to latex? YES NO
7. Are you allergic to local anesthetics? Specify: _____ YES NO
8. Are you allergic to penicillin? YES NO
9. Are you allergic to any other medications? YES NO
   If so, please list: _____
10. Are you pregnant or nursing? Due date: _____ YES NO
11. Do you prefer nitrous oxide ("laughing gas") for dental treatment? YES NO

Do you have or have you had any of the following?

	Y	N		Y	N		Y	N
High Blood Pressure			Tuberculosis			Fainting		
Low Blood Pressure			Emphysema			Seizures / Epilepsy		
Heart Attack			Chemotherapy			Stroke / TIA		
Heart Disease			Radiation Treatment			Thyroid Problem		
Heart Murmur/MVP			Cancer			Autoimmune Disease		
Pacemaker			Kidney Diseases			Leukemia		
Angina			Liver Disease			Diabetes		
Rheumatic Fever			Hepatitis			Stomach Problems		
Asthma			AIDS / HIV			STD		
Seasonal Allergies			Arthritis			Glaucoma		
Other Respiratory Problems			Joint Replacement Which_____When_____			Pins in Bones/Joints Which_____When_____		

All of the above information is true and correct to the best of my knowledge. I will inform Dr. Simmons of any changes in my health history prior to treatment.

Patient / Guardian Signature _____ Date _____