SIMONY DENTAL GROUP

41700 Hayes Rd., Suite D
Clinton Township, MI 48038
(586)-263-9300

Welcome to our office! We appreciate the confidence you place with us to provide dental services. To assist us in serving you, please complete the following form. The information provided on this form is important to your dental health. If there have been any changes in your health, please let us know.

Patient name: _____ Date of birth:_____ Age: _____
Gender: Male/Female Marital Status: Married/Single
Address:_____City:_____Zip:_____
Driver's License #: _____ S.S. #:_____
Preferred Phone: _____ Other: _____
E-mail: _____
Emergency Contact: _____ Phone Number:_____
Family Physician: _____ Phone Number:_____
Referred to the office by: _____

MEDICAL HEALTH HISTORY

Are you **allergic** to, or have you reacted adversely to any of the following?

- ❑ Latex Materials
- ❑ Penicillin or Other Antibiotics
- ❑ Local anesthetics ("Novocain")
- ❑ Codeine, Demerol or Other Narcotics
- ❑ Sulfa Drugs
- ❑ Barbiturates, Sedatives, or Sleeping pills
- ❑ Aspirin
- ❑ Acetaminophen or Ibuprofen
- ❑ Reaction to Metals
- ❑ Soy, Egg, Dairy, Nut Products
- ❑ Other:_____
- ❑ **None of the above**

Have you been hospitalized in the past 5 years? _____
If yes, why? _____

Are you presently under a physicians care? _____
If yes, why? _____

Do you smoke? _____
If yes, how often? _____

During the past 12 months, have you taken any of the following?

- ❑ Aspirin – On a daily basis? Yes / No
- ❑ Anticoagulants (Blood Thinners)
- ❑ Antibiotics or Sulfa Drugs
- ❑ High Blood Pressure Medicine
- ❑ Antidepressants or Tranquilizers
- ❑ Insulin or other Diabetic Drug
- ❑ Nitroglycerin
- ❑ Cortisone or Steroids
- ❑ Osteoporosis Medicine
- ❑ Non-Prescription Drugs/Supplements
- ❑ Oral Contraceptives Are you pregnant? _____
- ❑ Medications being taken presently:

_____

Do you have any other concerns that we should be aware of? _____
_____

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Do you have or have you had any of the medical conditions?

- ❑ Cancer or Tumor
- ❑ Heart Disease or Angina
- ❑ Heart Murmur, Mitral Valve Prolapse, Heart Defect
- ❑ Rheumatic fever or Rheumatic Heart Disease
- ❑ Artificial Joint or Valve
- ❑ High or Low Blood Pressure _____
- ❑ Pacemaker
- ❑ Tuberculosis or Lung Problems
- ❑ Kidney Disease
- ❑ Hepatitis or Liver disease
- ❑ Diabetes
- ❑ Thyroid Disease
- ❑ Neurologic condition
- ❑ Epilepsy, Seizures, or Fainting Spells
- ❑ Arthritis
- ❑ Herpes or cold sores
- ❑ AIDS or HIV positive
- ❑ Hepatitis A / B / C
- ❑ Migraine Headaches or Frequent Headaches
- ❑ Anemia or Blood Disorder
- ❑ Abnormal Bleeding Problems
- ❑ Sinus Problems
- ❑ Asthma
- ❑ Other: _____

We feel that it is necessary to develop a relationship with our patients and to know and understand your dental needs and/or concerns. Please complete the following questions to better help us get to know you.

What is the reason for your visit today? _____

What is the approximate date of your last dental cleaning? _____

Have you ever had serious problems and/or an emergency associated with previous dental treatment? Y / N If yes, what was the problem and/or emergency?

_____

Do you have headaches or jaw pain? Y / N

Would you like your teeth to be whiter? Y / N

Dr. Simony believes in having confidence in your smile. Please ask the front desk for more information regarding scheduling a consult.

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We are committed to providing you with the best dental care. Our fees reflect our professional commitment to excellence. Payment is due in full at the time of service unless other arrangements are made. Please ask the front desk for more information.

Your appointment is a commitment of time between you and our office. If you find that you cannot keep your appointment, please contact our office within 48 hours to make other arrangements. If you do not make the office aware of this change, you will be subject to a $40.00 cancellation fee.

As our patient we want you to know that we respect the privacy of your personal dental records and will do all that we can to secure and protect that privacy. When it is appropriate and necessary, we provide the minimum information to only those we feel are in need of your health care. You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under the law, we have the right to treat you should you choose to refuse to disclose your Personal Health Information.

In signing, you have read and agree to the above statements.

Signature of Patient _____ Date_____