

SIMPSONVILLE DENTAL ASSOCIATES
ADULT EXAMINATION QUESTIONNAIRE

APPOINTMENT POLICY

Appointment times are reserved exclusively for each patient. Please provide 24 hours notice to change or cancel an appointment, otherwise, there will be a charge to your account.

DATE _____

Name _____ Name you would like to be called _____

Address _____ E-mail: _____

City & State _____

Zip Code _____ Home Phone Number _____ Cell # _____

Occupation _____

Employer _____

Business Address _____

Business Phone _____ Ext. _____

Date of Birth _____ Marital Status _____ Spouse's Name _____

Spouse's Occupation _____

Spouse's Employer _____

Spouse's Business Address _____

Spouse's Business Phone _____ Ext _____

Do you have dental insurance through your employer? _____ or Spouse's? _____ or Both? _____

If you would like us to accept assignment of your insurance benefits please sign the following:

I hereby authorize payment to Simpsonville Dental Associates, PA of the insurance benefits otherwise payable to me:

Signed (Insured Person)

INSURANCE ID# _____

Social Security Numbers Yours _____ Spouse SS# _____

Spouse date of birth _____

How long since your last medical examination? _____

Medications you are taking _____

Name of your physician _____

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

Please indicate with a check mark:

- | | |
|---|---|
| <input type="checkbox"/> Any heart problems | <input type="checkbox"/> Joint or Hip Replacement |
| <input type="checkbox"/> Circulatory problems | <input type="checkbox"/> Use of any form of tobacco |
| <input type="checkbox"/> Problems with blood pressure | <input type="checkbox"/> HIV (AIDS Virus) |
| <input type="checkbox"/> Are you pregnant | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Drug Allergies, list _____ |
| <input type="checkbox"/> Psychiatric care | <input type="checkbox"/> Other Allergies _____ |
| <input type="checkbox"/> Excessive bleeding | <input type="checkbox"/> Heart murmur |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Stroke |
| | <input type="checkbox"/> Ulcer |

Have you been treated with **Bisphosphonate** drugs? _____

Other important medical history _____

Name of your previous dentist _____

How did you choose our office? _____

Name of nearest relative not living with you and relationship _____

Relative's phone number _____

List family members who are patients in our office _____

I prefer to pay my portion of any charges with:

Cash Check VISA Mastercard Discover American Express

Signature of responsible party