MICHAEL R. SIMON, D.D.S

Malaga Cove Dental Arts 36 Malaga Cove Plaza #310 Palos Verdes Estates CA 90274

Today's Date: _____

PATIENT NAME: _____ Preferred Name: _____
First MI Last

Address: _____ Male:___Female ____ Date of Birth: ____/____/_____

_____ Status (circle one) Single Married Divorced Widowed

Email Address: _____ SS# _____

Home Phone: _____ Employer: _____

Work Phone _____ Employer Address: _____

Mobile Phone: _____ How Long There: _____ Occupation: _____

Whom may we thank for referring you: _____

SPOUSE NAME _____ Employer: _____

Date of Birth: ____/____/_____ SS# _____ Phone # _____

PERSON RESPONSIBLE FOR ACCOUNT: Name: _____ Phone: _____

Address: _____ Relationship: _____

INSURANCE INFORMATION Do you have dental coverage: Yes ___ No _____

Ins Co Name _____ Phone: _____

Address _____ Insured's Name: _____

_____ Insured Birthdate: ____/_____/_____ Relation: ____

Insured's Employer: _____ Insured ID# _____

Address: _____ Do you have secondary insurance: _____

IN CASE OF EMERGENCY His/Her Name: _____ Relation: _____

Home # _____ Mobile # _____

MICHAEL SIMON, D.D.S.
36 Malaga Cove Plaza Palos Verdes Estates CA 90277

HIPAA NOTICE OF PRIVACY PRACTICES

I give Malaga Cove Dental Arts my consent to use or disclose my health information to carry out my treatment and to receive payment from my insurance.

I give my consent to Malaga Cove Dental Arts to send reminders to my home/or leave messages on my cell phone, email, voice mail/answering machine regarding dental work, appointments, billing or any other information.

I understand I can revoke my consent at any time, as long as I make my request in writing except for information already used or disclosed information.

Malaga Cove Dental Arts has my permission to perform all treatment diagnostic, preventive and therapeutic for necessary proper dental care. I can request a copy of the Notice of Privacy Practices - available upon request.

Print Patient Name _____ Signature _____ Date _____

I give Malaga Cove Dental Arts permission to share any of my information regarding existing and future dental work, billing and appointments with the following:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

FINANCIAL POLICY - OFFICE POLICY

- Your insurance is a contract between you and your insurance company,we are not a part of that contract. Most insurance companies pay a percentage of the cost, you are responsible for what insurance does not cover. We ask that you provide all insurance information and we will submit claims to your insurance as a courtesy to you.
- I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance, and may be billed for this remaining balance. I consent and agree to be financially responsible for payment on myself and on behalf of my dependants (if any)
- I hereby authorize the Assignment of Benefits to Michael R. Simon DDS, dba Malaga Cove Dental Arts.
-If you have insurance, you are responsible for your estimated patient portion at the time service is rendered.
-If you do not have insurance, payment in full is due at the time service is rendered.
- I agree to pay all collection costs, interest and reasonable attorney fees in the event this account of any future account of mine/ours is turned over to our attorney or collection agency.

I authorize the dental office staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent. It is my responsibility as the patient to inform the dental office of any changes in my health status, insurance coverage and contact information.

TO AVOID A CANCELLATION FEE A 48 HOUR NOTICE IS REQUIRED

Signature: _____ Date: _____
Patient, parent or legal guardian

Dr. Michael R. Simon DDS/Malaga Cove Dental Arts

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36 Malaga Cove Plaza | Suite 310 • Palos Verdes Estates, CA 90274 (310)375-8888

MEDICAL HISTORY FORM

Patient Name: _____ * _____ * ___ _____
Last First MI Preferred Name

Please take a moment to let us know about your medical and dental history so we may serve you more effectively and in a way that watches out for your overall health and well-being.

Within the past year, have there been any changes in your general health?

_____

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

Your Primary Care Physician's name, address, & phone number:

_____

Please mark any of the following to indicate YES in response to the question:

- ☐ Are you currently under the care of a physician due to a specific condition?
- ☐ Have you been hospitalized within the last 5 years due to a surgery or illness?
- ☐ Are you currently taking any prescription or non-prescription medications?
- ☐ Do you use tobacco (smoking or chewing)?
- ☐ Do you have any other conditions, diseases, etc., not listed above that we should be aware of?

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

_____

What is the reason for your dental visit today?

_____

When was your last visit to the dentist (if to a different office)?

_____

What was done on your last dental visit (if to a different office)?

_____

Prior Dentist's name, address, & phone number:

_____

Please check box any of the following to indicate Yes in response to any of the questions:

- ☐ Do your gums bleed when you brush or floss?
- ☐ Do your teeth experience sensitivity to cold or hot temperatures?Sweet foods or pressure?
- ☐ Are any of your teeth currently causing you pain?
- ☐ Do you grind your teeth (either consciously or during sleep)?
- ☐ Are any of your teeth loose, or are you concerned about any teeth loosening?
- ☐ Do you currently have any dental implants, dentures, or partials?
- ☐ Have you ever had complications following dental treatment?
- ☐ Your current dental health: (GOOD / FAIR / POOR)
- ☐ Do you have fears about going to the dentist?
- ☐ Have you ever had gum treatment/ gum surgery?
- ☐ Do you now or have you ever experienced pain/ discomfort in your jaw joint? (TMJ/TMD)
- ☐ Do you like your smile?
- ☐ Are you happy with the apperance of your teeth or old dental work?

If any of the previous questions are marked, please explain: _____

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

Patient Name:_____Date:_____

WOMEN ONLY: Are you pregnant? If Yes, when is the due date?_____

Are you allergic to any of the following?

☐ Aspirin ☐ Codeine ☐ Dental Anesthetics ☐ Erythromycin ☐ Latex ☐ Penicillin
☐ Tetracycline ☐ OTHER

If OTHER please list: _____

Please list all current Medications:

_____

Please check box if you have experienced any of the following:

☐ PRE-MED	☐ Alcohol/ Drug Abuse	☐ Allergies
☐ Anemia	☐ Arthritis	☐ Artificial Joints/ Valves
☐ Blood Disease/ Hemophilia	☐ Blood Transfusion	☐ Breathing Difficulty/ Emphysema
☐ Cancer/ Chemotherapy	☐ Congenital Heart Defect	☐ Diabetes
☐ Dizziness/ Fainting	☐ Epilepsy/ Seizures	☐ Excessive Bleeding
☐ Glaucoma	☐ Growths	☐ Hay Fever
☐ Headaches	☐ Head Injuries	☐ Heart Disease/ Heart Attack
☐ Heart Murmur	☐ Heart Valve Replacement/ Heart Surgery	☐ Hepatitis
☐ Herpes/ Fever Blisters	☐ High Blood Pressure/ Low	☐ HIV/ AIDS
☐ Jaundice	☐ Kidney Disease	☐ Liver Disease
☐ Lupus	☐ Mental Disorders	☐ Mitral Valve Prolapse
☐ Multiple Sclerosis	☐ N2O	☐ Nervous Disorders
☐ No EPI	☐ Osteoporosis/ Paget's Disease	☐ Other
☐ Pacemaker	☐ Pregnancy	☐ Psychiatric Treatment
☐ Radiation Treatment	☐ Respiratory Problems	☐ Rheumatic Fever/ Scarlet Fever
☐ Rheumatism	☐ Shingles	☐ Sickle Cell Disease
☐ Sinus Problems	☐ STD/ VD	☐ Stomach Problems/ Colitis
☐ Stroke	☐ Taking Medications	☐ Thyroid Problems
☐ Tuberculosis	☐ Tumors	☐ Ulcers

Please list any other health issues that you may have: _____

DO YOU REQUIRE ANTIBIOTICS PIOR TO DENTAL TREATMENT? ◯ Yes ◯ No

How frequently do you brush your teeth?

☐ 3 (+) a day ☐ Twice a day ☐ Once a day ☐ Weekly ☐ Seldom

TO THE BEST OF MY KNOWLEDGE, ALL OF THE PRECEDING INFORMATION IS TRUE AND CORRECT. IF I EVER HAVE A CHANGE IN MY HEALTH, I WILL INFORM THE OFFICE AT MY NEXT DENTAL APPOINTMENT WITHOUT FAIL. PATIENT SIGNATURE: _____ DATE:_____

------ OFFICE USE ONLY--------- OFFICE USE ONLY-------OFFICE USE ONLY --------OFFICE USE ONLY---------OFFICE USE ONLY -------

Doctors Comments:_____

I verbally reviewed the medical/ dental information above with the patient name herein. Dr. Initials: _____Date: _____

I HAVE READ MY MEDICAL HISTORY DATED AND CONFIRMED THAT IT STATES PAST AND PRESENT MEDICAL CONDITIONS.

SIGNATURE:_____DATE:_____Change:_____

I HAVE READ MY MEDICAL HISTORY DATED AND CONFIRMED THAT IT STATES PAST AND PRESENT MEDICAL CONDITIONS.

SIGNATURE:_____DATE:_____Change:_____