



Daniel J. Simon, DMD • Staci N. Greer, DMD • Leslie S. Campbell, DMD
625 Three Springs Road • Bowling Green, KY 42104
(270) 782-5115

Patient Information

Patient Name _____ Date _____
Last, First MI (Preferred Name)
Gender: _____ Family Status: _____ Social Security #: _____ Birth Date: _____
Email Address: _____
Phone (Home): _____ (Work): _____ Ext: _____ Cell Phone: _____
Address: _____
Street Apartment #
City State Zip Code

Health Information

Date of Last Dental Visit: _____ Reason for this visit: _____

Have you ever had any of the following? Please check those that apply:

- AIDS, Excessive Bleeding, Kidney Disease, Stomach Problems
Allergies, Fainting, Liver Disease, Stroke
Anemia, Glaucoma, Mental Disorders, Tuberculosis
Arthritis, Growths, Nervous Disorders, Tumors
Artificial Joints, Hay Fever, Pacemaker, Ulcers
Asthma, Head Injuries, Pregnancy, Venereal Disease
Blood Disease, Heart Disease, Due date: _____, Codeine Allergy
Cancer, Heart Murmur, Radiation Treatment, Penicillin Allergy
Diabetes, Hepatitis, Respiratory Problems, Latex Allergy
Dizziness, Hereditary Angioedema, Rheumatic Fever, OTHER:
Epilepsy, High Blood Pressure, Rheumatism,
Jaundice, Sinus Problems

- Have you ever had any complications following dental treatment? Yes No
Have you been admitted to a hospital or needed emergency care during the past two years? Yes No
Are you now under the care of a physician? Yes No
Name of Physician: _____ Phone: _____
Do you have any health problems that need further clarification? Yes No

Please list any medications: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct.
If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Signature of patient, parent or guardian _____ Date: _____

Referral Information

Whom may we thank for referring you to our practice? Another patient, friend Another patient, relative
Dental Office Yellow Pages Newspaper School Work Other
Name of person or office referring you to our practice: _____

Simon Dentistry

Spouse or Responsible Party Information

Name: _____
 Male Female Married Single Other _____
Social Security #: _____ Birth Date: _____
Phone (Home): _____ (Work): _____ Ext: _____ Cell Phone: _____
Address: _____
Street _____ Apartment # _____
City _____ State _____ Zip Code _____

Employment Information

The following is for: the patient the person responsible for payment
Employer Name: _____ Occupation: _____
Address: _____
Street _____ City _____ State _____ Zip Code _____ Phone _____

Insurance Information

Primary
Name of Insured: _____ Is insured a patient? Yes No
Last First MI
Insured's Birth Date: _____ ID #: _____ Group #: _____
Insured's Address: _____
Street _____ City _____ State _____ Zip Code _____
Insured's Employer Name: _____
Address: _____
Street _____ City _____ State _____ Zip Code _____
Patient's relationship to insured: Self Spouse Child Other _____
Insurance Plan Name and Address: _____

Secondary
Name of Insured: _____ Is insured a patient? Yes No
Last First MI
Insured's Birth Date: _____ ID #: _____ Group #: _____
Insured's Address: _____
Street _____ City _____ State _____ Zip Code _____
Insured's Employer Name: _____
Address: _____
Street _____ City _____ State _____ Zip Code _____
Patient's relationship to insured: Self Spouse Child Other _____
Insurance Plan Name and Address: _____

Consent for Services

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

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

Patients who carry dental insurance understand that all dental services furnished 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 patients insurance forms or assist in making collections from insurance companies and will credit any such 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.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. 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 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 at home or at my work to discuss matters related to this form.

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

Signature of patient, parent or guardian Date: _____ Relationship to Patient: _____

Signature of guarantor of payment/responsible party Date: _____ Relationship to Patient: _____



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ACKNOWLEDGEMENT OF RECEIPTS OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I _____, have reviewed a copy of this office's Notice of
privacy Practices. (HIPAA STATEMENT)

Please PRINT Name

Signature

Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but
acknowledgement could not be obtained because:

- ❖ Individual refused to sign
 - ❖ Communication barriers prohibited obtaining the Acknowledgement
 - ❖ An emergency situation prevented us from obtaining acknowledgement
 - ❖ Other...as specified below
-



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FINANCIAL POLICY

Our mission is to provide you with a family like atmosphere in an up-to-date facility where you can be certain that you are given the very best care for your dental needs. In addition, we recognize the need for a clear understanding of your financial obligations for the treatment you receive. In order to create a better understanding between patients and our office, we have adopted the following policy. If you have any questions about this policy, we encourage you to contact our Patient Accounts Department.

PATIENTS WITHOUT INSURANCE COVERAGE

Unless prior arrangements are made with our Patient Accounts Department, **payment in full is due on the day of service.** For your convenience we accept: cash, check, Care Credit, and all major credit cards. For dental procedures over \$200.00, a 10% cash discount will be applied if the patient's balance is paid in full on the day of service. A discount cannot be given for any implant and Botox® procedures.

PATIENTS WITH INSURANCE COVERAGE

We participate with numerous insurance plans and will gladly file your dental claim for you. This is a service provided by the office. Benefits will be assigned to us and insurance payments will be made directly to the office. We will attempt to collect payment from the insurance company for up to 90 days. If payment is not received in that amount of time, the patient will be held responsible for payment. We will gladly continue to assist you in recovering payment from the insurance company. **Deductibles and co-payments are due the day of service.** Ultimately, the patient is responsible for the balance in full if payment is not received from the insurance company.

RETURNED CHECKS

Returned checks will incur a \$25.00 service fee.

COLLECTION

The undersigned understands and agrees that the account balance is due, in full, upon receipt of the statement. If the account is not paid in full within 90 days from the date of service, and Simon Dentistry should retain an attorney or collection agency for collection, the undersigned agrees to reimburse Simon Dentistry the collection fess of any collection agency, which shall be based on a percentage at a maximum rate of 33 1/3% of the amount due at the time your account is placed with a collection agency, and all costs and expenses incurred for any collection agency. This contract shall cover all medical treatment and services until revoked by either party in writing.

CARE CREDIT

Because your smile is important to us, we offer Care Credit, a healthcare credit card specifically designed to pay for dental treatments and procedures not covered by insurance. Ask us about Care Credit today and how you may receive up to 12 months with deferred interest.

MISSED APPOINTMENT FEE

As a courtesy to our office, we ask our patients to give a 24-48 hour notice if the scheduled appointment must be broken. However, if no notice is given, a missed appointment fee of \$50.00 will be charged to the patient's billing statement.

SIGNATURE _____ **DATE:** _____