THOMAS A. SIMMONS, DDS, PA
PATIENT HISTORY FORM

Date:_____Name:_____
Single___Divorced____Married____Other____ Male_____Female_____
Birthdate:_____Address:_____
City:_____State:_____Zip:_____
Home#:_____Cell#:_____Wk#:_____
SS#:_____DL#:_____Email:_____
How did you hear about us: _____
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Medical History: PLEASE DO NOT SKIP…ANSWER YES OR NO TO ALL.

_____HEART DISEASE
_____HIGH/LOW BLOOD PRESSURE
_____RHEUMATIC FEVER/HEART VALVE DISEASE
_____RESPIRATORY DISEASE/EMPHYSEMA
_____DIABETES
_____HEADACHES
_____CANCER/RADIATION
_____HEPATITIS
_____HIV / AIDS
_____SMOKER
_____STROKE / VASCULAR DISEASE
_____ARTIFICIAL VALVE OR JOINTS
_____ARTHRITIS
_____LOUD SNORING
_____PSYCHIATRIC CARE
_____EPILEPSY
_____ALCOHOLISM OR DRUG ABUSE
_____GRINDING TEETH
_____ANY OTHER DISORDERS

WOMEN:
BIRTH CONTROL?_____PREGNANT?_____ PLAN PREGNANCY?_____NURSING?_____

LIST MEDICATIONS YOU ARE CURRENTLY TAKING & WHY:

_____
_____

ALLERGIES TO MEDICATIONS: _____

EMERGENCY
CONTACT:_____PH#:_____
EMERGENCY
CONTACT:_____PH#:_____
PHYSICIAN:_____PH#:_____

INSURANCE:
MAIN INSURED
NAME:_____
EMPLOYER:_____SS#_____DOB:_____
NAME OF INSURANCE COMPANY:_____
INSURANCE ID#_____GROUP#:_____
CUSTOMER SERVICE #:_____

****OUR OFFICE ONLY FILES YOUR PRIMARY INSURANCE****

THE ABOVE INFORMATION IS ACCURATE & COMPLETE TO THE BEST OF MY KNOWLEDGE. I AM AWARE THAT MY INSURANCE WILL BE FILED AS A COURTESY AND I AM RESPONSIBLE FOR ALL COPAYS AT THE TIME OF SERVICE. I AM RESPONSIBLE FOR ANY BALANCE UNPAID BY MY INSURANCE COMPANY AND FOR KEEPING THE OFFICE UPDATED AT ALL TIMES OF ANY CHANGES IN REGARDS TO MY INSURANCE COVERAGE.

_____ _____
RESPONSIBLE PARTY SIGNATURE DATE

_____ _____
DOCTOR SIGNATURE DATE