Welcome to Marie Simon Dentistry!

Since I was a little girl, I wanted to help people smile more often and more beautifully – to be proud of their smile. For more than 20 years now, I've had the incredible privilege of creating personalized smiles to help people discover renewed confidence, a new outlook on life and fresh enthusiasm for their future. It has been my unique pleasure to see first-hand the transformational power of a new smile.

At Marie Simon Dentistry, we specialize in designing and creating your dream smile. The magic happens when technical expertise melds with tailored design, guided by artistic talent, to fashion a personalized and beautiful smile. Unlike general dentistry, precision cosmetic dentistry requires specific and extensive training beyond dental school.

After understanding your goals, we will encourage you to allow us to complete a comprehensive study of your oral health and aesthetics. A thorough set of diagnostic tools will be used to gather information about your smile, your gums, and your teeth. These tools will also provide ways to communicate with you about the possibilities for your smile.

To top off your **Personalized Smile Design Session**, we will show you what a **Customized Smile Plan** would look like for you.

Your dream smile is our driving passion and exceeding your expectations is our goal. See what a new smile could do for you!

I look forward to seeing you soon!

DR. MARIE SIMON

375 LEAR ROAD • SUITE G AVON LAKE • OHIO 44012 440 • 933 • 3270 PERFECTINGTHESMILE.COM

MARIE SIMON DENTISTRY

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375 Lear Road Suite G I Avon Lake, Oh 44012
440-933-3270 I perfectingthesmile.com

Email Address _____

Patient Name _____ □ Male ☐ Female

Birth date _____/____/_____ **Age** _____ **Social Security Number** _____

Home Address _____

City, State and Zip Code _____

How did you hear of Marie Simon Dentistry?

☐ Friend or Family
☐ Internet Search
☐ Sign or Location
☐ Postcard or Mailing
☐ Other: _____

Are you:

☐ Single ☐ Married ☐ Partnered ☐ Divorced/Separated ☐ Widowed

Home Phone _____ **Cell Phone** _____

Work Phone _____ **Ext** _____ **Direct Line** _____

Where and when are the best times to reach you? _____

EMPLOYER

Occupation _____ Name of Employer _____

DENTAL INSURANCE

Name of Insurance _____

Address_____ Phone _____

Subscriber Name _____ DOB _____

SSN _____ Employer _____

I am responsible for payment for services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to Marie Simon Dentistry. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered to my insurance company, or any other medical/dental facility needed for treatment. I give authority for Marie Simon Dentistry to release any information necessary to other professionals dental/medical or insurance.

Signature _____ Date _____

DENTAL HISTORY

What brings you to the dentist today? _____

Are you currently in any pain?	____ **Y** ____ **N**
Do you require antibiotics before dental treatment?	____ **Y** ____ **N**
Your current dental health is	____ **Good** ____ **Fair** ____ **Poor**
Do you floss daily?	____ **Y** ____ **N**
Brush daily?	____ **Y** ____ **N**
What type of bristle does your toothbrush have?	____ **Hard** ____ **Soft** ____ **Medium**
Do your gums bleed?	____ **Y** ____ **N**
Have you ever had periodontal disease?	____ **Y** ____ **N**
Are you sensitive to heat, cold or anything else?	_____
Do you have mobility in your teeth?	____ **Y** ____ **N**
Do you still have your wisdom teeth?	____ **Y** ____ **N**
Would you like fresher breath?	____ **Y** ____ **N**
Would you like whiter teeth?	____ **Y** ____ **N**
Are you happy with the way your smile looks?	____ **Y** ____ **N**

If not, what would you change? _____

Who was your previous/present dentist? _____

When was your last appointment? _____

Why did you leave? _____

MEDICAL HISTORY

Do you have a physician? ____ **Y** ____ **N** Physician's Name _____

Address _____ Phone Number _____

Are you currently under his/her care? ____ **Y** ____ **N** If yes, please explain: _____

Last date of your last visit _____ Your current health is ____ **Good** ____ **Fair** ____ **Poor**

Do you smoke or use tobacco? ____ **Y** ____ **N**
Have you ever taken Phen-Phen, Redux, or Pondimin? ____ **Y** ____ **N**
Are you currently taking any prescription or over-the-counter drugs? ____ **Y** ____ **N**

If yes, please list: _____

WOMEN: Are you taking birth control? ____ **Y** ____ **N**
Are you pregnant? ____ **Y** ____ **N** Week # _____
Nursing? ____ **Y** ____ **N**

Do you have or have you had any of the following conditions? Please circle all that apply.

Abnormal Bleeding	Colitis	Hay Fever	Liver Disease	Shingles
Alcohol Abuse	Congenital Hrt Defect	Headaches	Low Blood Pressure	Sickle Cell Anemia
Anemia	Diabetes	Heart Attack	Lupus	Sinus Problems
Arthritis	Difficult Breathing	Heart Murmur	Mitral Valve Prolapse	Steroid Therapy
Artificial Valve	Drug Abuse	Heart Surgery	Pacemaker	Stroke
Asthma	Emphysema	Hemophilia	Persistent Cough	Thyroid Problems
Blood Transfusion	Ever Hospitalized	Hepatitis	Radiation Treatment	Tuberculosis
Cancer	Fainting Spells	Herpes	Rheumatic Fever	Ulcers
Chemotherapy	Fever Blisters	High Blood Pressure	Scarlet Fever	Venereal Disease
Chicken Pox	Glaucoma	HIV+ AIDS	Seizures	

Please list any other serious medical conditions you have had: _____

_____

Are you allergic to any of the following? Please circle all that apply.

Aspirin	Codeine	Barbiturates	Erythromycin	Latex	Sedatives	Tetracycline
Dental Anes	Jewelry	Metals	Penicillin	Sulfa Drugs		

Please list any other allergies you may have: _____

_____

I affirm that the information I have given is correct to the best of my knowledge, and that it is my responsibility to inform this office of any changes in my medical status. I authorize the staff of Marie Simon Dentistry to perform the necessary services I may need. I assign the doctor all insurance benefits. I understand that I am responsible for any and all payments for services rendered, even if my insurance does not cover those services. I have received a copy of the Notice of Privacy Practice.

Signature _____ Date _____