PATIENT INFORMATION

Patient Name _____

Address _____

_____ _____ _____

City State zip

Phone# _____ Cell# _____

Work# _____ Sex M F Age _____

Patient SS# _____ Birth Date _____

DL# _____ Marital Status _____

Email Address _____

Employer/School Attending _____

Employer # _____

Spouse/Guardian _____

Birth Date _____ SS# _____

Cell# _____ Work# _____

Spouse/Guardian's Employer _____

Person to notify in case of emergency not living with you

_____

Whom may we thank for this referral _____

INSURANCE INFORMATION

Employee Name _____

Employee SS# _____ Birthday _____

Employer Name _____

Name of Insurance Co. _____

Address _____

_____

City _____ State _____ Zip _____

Insurance Phone _____

ID# _____ Group# _____

Assignment and Release

I, undersigned Certify that I (or my dependant) have insurance coverage with _____ and assign directly to Today's Dental, P.A. all insurance benefits, if any, otherwise payable to me for services rendered. i understand that i am financially responsible for all charges whether or not paid by insurance. I hereby authorise the doctor to release all information necessary to secure the payment of benefits. I authorize the the use of this signature on all insurance submissions.

_____

Responsible Party Signature

_____

Relationship Date

Non-insurance patients are expected to pay in full with cash, check or credit card the day services are rendered.

Insured patents will assign benefits from their dental insurance company directly to our office, You must sign the "Assignment and Release" section above. This allows your dental insurance company to make payment to us directly to our office on your behalf. Most dental insurance plans do not cover 100% of the cost of your treatment. For this reason, you will be required to pay your deductible and an estimated portion of your charges the day services are rendered. Please keep in mind hat we are only estimating the amount that your insurance will pay us. Your insurance company will determine the exact amount that they will pay once they have received the actual claim. You are ultimately responsible for your account balance, including any short fall from your insurance company. As a courtesy to you, we will submit your claim to your primary insurance company. After 45 days, the balance Will be due from you in full.

Feel free to ask any questions that remain unanswered before you dental treatment.

Consent

I, the undersigned, hereby authorize the doctor to take radiographs, study models, photographs or any other diagnostic aids he/she deems appropriate to make a thorough diagnosis of my dental needs. I also authorize the doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I authorize and consent that the doctor employ any such assistance as he/she deems appropriate.

I further authorize the release of any information, including the diagnosis, radiographs and records of any treatments or examinations rendered to my insurance company, consulting professionals or others that may request my records.

I understand that I am personally responsible for payment of all fees for dental services provided in this office for me or my dependents, regardless of insurance coverage. Breach of this responsibility carries the penalty of compensating the practice for any related attorney's and collection fees. I understand that payment is due when services are rendered. Any other arrangements for payment must be made before treatment begins.

Minor patient of divorced or separated parents

In the case of divorce or separation, The party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

_____ _____ _____

Signature of patient or authorized responsible party | Relationship | Date

DENTAL HISTORY AND CONSENT FOR TREATMENT

MEDICAL QUESTIONNAIRE

Patient Name_____ **Date Today** _____

Please check if you have any of the following problems:

- ☐ AIDS / HIV Positive
- ☐ Alcoholism
- ☐ Allergies
  Describe _____
  _____
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial heart valves
- ☐ Artificial joints
- ☐ Asthma
- ☐ Back problems
- ☐ Blood disease
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Circulation problems
- ☐ Cortisone treatments
- ☐ Cough, persistent
- ☐ Cough, up blood
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting
- ☐ Food allergies
- ☐ Glaucoma
- ☐ Headaches, frequent
- ☐ Headaches, migraines
- ☐ Heart murmur
- ☐ Heart, any problems
  Describe_____
  _____
- ☐ Hemophilia
- ☐ Herpes
- ☐ Hepatitis A B C
- ☐ High blood pressure
- ☐ Jaw pain
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Mitral valve prolapse
- ☐ Nervous problems
- ☐ Pacemaker
- ☐ Psychiatric care
- ☐ Radiation treatment
- ☐ Respiratory disease
- ☐ Rheumatic fever
- ☐ Seizure disorders
- ☐ Shingles
- ☐ Shortness of breath
- ☐ Skin rash
- ☐ Stroke
- ☐ Surgical implants
- ☐ Swelling, feet or ankles
- ☐ Thyroid problems
- ☐ Tobacco use
- ☐ Tuberculosis
- ☐ Ulcers/colitis

Known Allergies:

- ☐ Local anesthetic
- ☐ Aspirin
- ☐ Penicillin
- ☐ Codeine
- ☐ Sulfa
- ☐ Iodine
- ☐ Latex
- ☐ Other:_____

List any medications you are currently taking:

_____
_____
_____
_____

Pre-medication required _____
Consulting Physician _____
Pharmacy _____

Check if you have had any problems with the following:

- ☐ Bad breath
- ☐ Bleeding, sensitive gums
- ☐ Clicking or popping jaw: right or left
- ☐ Food trapped between teeth
- ☐ Grinding or clenching teeth
- ☐ Loose teeth
- ☐ Broken fillings
- ☐ Periodontal treatment
- ☐ Sensitivity to cold
- ☐ Sensitivity to hot
- ☐ Sensitivity to sweets
- ☐ Sensitivity to biting
- ☐ Sores in mouth
- ☐ Staining

Authorization:
I have reviewed the information and answered all questions to the best of my knowledge. I understand this information will be used to determine the dental treatment I receive at this office and may be shared with other medical offices only as necessary. I will notify the office should any information change in the future.

Signature of patient, or parent if a minor: _____
Reviewed by: _____