

## Patient Information

Patient Name \_\_\_\_\_  
Address \_\_\_\_\_  
\_\_\_\_\_  
City State Zip  
Telephone \_\_\_\_\_ Cell # \_\_\_\_\_  
Work # \_\_\_\_\_ Sex: M F Age \_\_\_\_\_  
Patient SS# \_\_\_\_\_ Birthdate \_\_\_\_\_  
DL# \_\_\_\_\_ Marital Status \_\_\_\_\_  
Occupation/ Student Status \_\_\_\_\_  
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 # \_\_\_\_\_ Birthdate \_\_\_\_\_  
Employer Name \_\_\_\_\_  
Name of Insurance Co. \_\_\_\_\_  
Address \_\_\_\_\_  
\_\_\_\_\_  
City State Zip  
Insurance Telephone # \_\_\_\_\_  
ID# \_\_\_\_\_ Group # \_\_\_\_\_

### Assignment and Release

I, the 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 authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature \_\_\_\_\_

Relationship \_\_\_\_\_

Date \_\_\_\_\_

## Health History

Primary Care Physicians Name \_\_\_\_\_ Phone # \_\_\_\_\_ Last Visit \_\_\_\_\_  
Specialist Name \_\_\_\_\_ Phone # \_\_\_\_\_ Last Visit \_\_\_\_\_

Please indicate whether you have any of the following:

Autoimmune Disease/ HIV	Y / N	Artificial Joints	Y / N	Date: _____
Chemical Dependency	Y / N	Glaucoma	Y / N	
Diabetes	Y / N	High Blood Pressure	Y / N	Hep Y / N
Mitral Valve Prolapse	Y / N	Rheumatic Fever	Y / N	TB Y / N
Cardiac Conditions	Y / N	Please Explain: _____		

Any other medical problem not listed above: \_\_\_\_\_

Please list any prescription or over the counter medications that you are taking: \_\_\_\_\_

Please list allergies and reactions to any prescriptions or over the counter medications: \_\_\_\_\_

Females: Are you pregnant? Y / N Due Date: \_\_\_\_\_ Are you nursing? Y / N

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

**Insured patients** 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 that 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 your dental treatment.**

Patient Signature \_\_\_\_\_ Date: \_\_\_\_\_