PATIENT INFORMATI[illegible]

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 ____________

INS[illegible]ANCE INFORMATION

Employee Name ____________________

Employee SS# ____________ Birthday ____________

Employer Name ____________________

Name of Insurance Co. ____________________

Address ____________________

City ____________ State ______ Zip ______

Insurance Phone ____________________

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 he 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

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 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 you dental treatment.

With my consent, Today's Dental, P.A. may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to their Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing these consent. Today's Dental, P.A.. reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Today's Dental, P.A., Attn.: Privacy Officer, at 209 W. Main St., Azle, Texas 76020.

With my consent, Today's Dental, P.A. may call my home or other designated location, and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, and any call pertaining to my clinical care, including test results among others.

With my consent, Today's Dental P.A. may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

I have the right to request that Today's Dental, P.A. restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Today's Dental, P.A. use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance up on my prior consent.

If I do not sign this consent, Today's Dental, P.A. may decline to provide treatment to me.

____________________ ____________

Signature of Patient or Legal Guardian Date

____________________ ____________

Printed Name of Patient Witness

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: ____________

TODAY'S DENTAL, P.A.

Dental Care with a Gentle Touch