TODAY'S DENTAL

3944 FM 1960 West • Houston, Texas 77068-3521 • 281-580-0770 • www.todaysdental.net

PATIENT INFORMATION

DATE _____

Name _____ Preferred Name _____

Spouse's Name _____ Patient's Name If Child _____

Home Address _____ City _____ Zip _____

Home Phone _____ Birthday _____

Cell Number Mr. _____ Business Mr. _____

Cell Number Mrs. _____ Business Mrs. _____

Social Security # Mr. _____ Email Address Mr. _____

Social Security # Mrs. _____ Email Address Mrs. _____

Referred by _____ Drivers License # _____

Dependent Children: Name _____ Age _____

Name _____ Age _____

Name _____ Age _____

How would you like to have your appointments confirmed? ❑ Email ❑ Home ❑ Office ❑ Cell

PATIENT/PARENT'S EMPLOYER _____

Position _____ Dental Insurance? Yes / No

Name of Dental Insurance _____ Insured's DOB _____

Insurance Address _____ Phone # _____

Group # _____ Subscriber #/Social Security # _____

SPOUSE'S EMPLOYER _____

Position _____ Dental Insurance? Yes / No

Name of Dental Insurance _____ Insured's DOB _____

Insurance Address _____ Phone # _____

Group # _____ Subscriber #/Social Security # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____
Name of Insurance Company(ies)

and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I an financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature submissions.

The above named dentist may use my health care information and may disclose such information to the above named insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Deductible and percentage that insurance will not cover is to be paid AT THE TIME OF SERVICE. As a courtesy to you we will file your insurance for payment. We will allow no more than 45 days from date of service for payment from your insurance company, at that time you will be expected to make payment in full or financial Agreement must be in order.

Signature of Patient, Parent, Guardian or Personal Representative _____ Date _____

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MEDICAL HISTORY

Last Name _____ First _____ Birth Date _____

Who should we contact in an emergency? _____ Phone _____

Are you currently under treatment or therapy? _____ For what? _____

_____

Physician's Name _____ Phone _____

Medications you are currently taking, including herbal supplements and over-the-counter drugs _____

_____

Pharmacy Name & Phone # _____

Do you have or have you had:	No	Yes	Date	Comments
Heart Trouble				
High Blood Pressure				
Low Blood Pressure				
Heart Murmur				
Mitral Valve Prolapse				
Heart Implant (Valve, Stent, Pacemaker)				
Rheumatic Fever				
Joint Replacement				
Tuberculosis				
Emphysema				
Asthma				
Seasonal Allergies				
Seizures or Epilepsy				
Stroke				
Veneral Disease (Type)				
HIV or AIDS				
Liver Disease				
Hepatitis (Type)				
Major Surgery (Type)				
Blood Transfusion				
Blood Disorder (Anemia, Leukemia)				
Bleeding Problems				
Diabetes				
Arthritis (Type)				
Cancer (Type)				
Chemotherapy				
Radiation Therapy				
Thyroid Disorder				
Kidney Disorder				
Stomach Ulcers				
Osteoporosis				
Drug or Alcohol Abuse				
Emotional or Psychological Disorder				
Acid Reflux (GERD)				
Heartburn				
Glaucoma				

Any Other Medical Conditions? _____

_____

_____

Initial _____

Continued on back

Have you ever had a reaction to:	No	Yes	Describe
Penicillin			
Erythromycin			
Tetracycline			
Codeine			
Aspirin			
Acetaminophen			
Ibuprofen			
Sulfa			
Metals			
Latex			
Acrylic			
Other			

Do you use:	No	Yes	Type	Quantity
Tobacco				
Alcohol				
Drugs				

Are You:	No	Yes	
Hearing Impaired			
Visually Impaired			
Other Disabilities			

Are you aware that there is a detrimental relationship between gum disease and systemic diseases such as Diabetes and Heart Disease?

Do you take blood thinners or daily aspirn? ❑ Yes ❑ No

Do you or have you taken bone building drugs? (Fosomax, Reclast, etc.) ❑ Yes ❑ No

Women:	No	Yes	
Are you pregnant?			Due Date
Are you taking Hormone Replacement?			If Yes, Type
Are you taking Birth Control Pills?			If Yes, Type

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Patient Name _____ Date _____

DENTAL HISTORY & PATIENT PROFILE

1. How did you hear about our practice? _____
2. How can we help you? (The reason for your visit)
   _____ Improve the appearance of teeth/smile
   _____ Overall dental health and prevention of tooth loss
   _____ Toothache/ Pain
3. How have your dental experiences been in the past?
   ____ Excellent _____ Fair _____ Frightening/Painful
   If frightening, what causes this? _____
   _____
   What could we do to help with this?_____
   _____
4. Have you had regular checkups and cleanings over the past several years?_____
5. When was your last cleaning?_____
6. If applicable, why have you neglected your dental health for so long?
   ____ Money ____ Time ____ Procrastination ____ Pain/Fear ____ Insurance
7. Why did you leave the dental office that treated you previously? _____
   _____
   Explain how we can improve/resolve this problem in our office, If possible. _____
   _____
8. Have you lost any teeth? _____
9. Do any of your family members wear dentures or partials_____
   If yes, did they lose their teeth at an early age? _____
10. Do your gums ever bleed when you brush? _____ How often do you brush? _____
    Floss? _____ How often do you floss? _____
11. Do you think your breath is fresh as it could be? _____
12. Do you like your smile? _____ What would you change if you could? _____
13. What days/times are most convenient for you? Days_____ Times_____

DENTAL HISTORY

Former Dentist _____City/State_____

Date of Last Dental Visit _____ Date of Last Dental X-rays_____

Place a mark on "yes" or "no" to indicate if you have had any of the following:

Ulcers on Lips or Mouth	❑ Yes	❑ No	Grinding/or Clinching Teeth	❑ Yes	❑ No	Pain Around Ear	❑ Yes	❑ No
Burning Sensation on Tongue	❑ Yes	❑ No	Gums Swollen or Tender	❑ Yes	❑ No	Sensitivity to Cold	❑ Yes	❑ No
Chew on One Side of Mouth	❑ Yes	❑ No	Jaw Pain or Tiredness	❑ Yes	❑ No	Sensitivity to Heat	❑ Yes	❑ No
Cigarette, Pipe or Cigar Smoking	❑ Yes	❑ No	Lip or Cheek Biting	❑ Yes	❑ No	Sensitivity to Sweets	❑ Yes	❑ No
Clicking or Popping Jaw	❑ Yes	❑ No	Loose Teeth or Broken Fillings	❑ Yes	❑ No	Sensitivity When Biting	❑ Yes	❑ No
Dry Mouth	❑ Yes	❑ No	Mouth Breathing	❑ Yes	❑ No	Sores or Growths in Your Mouth	❑ Yes	❑ No
Fingernail Biting	❑ Yes	❑ No	Mouth Pain, Brushing	❑ Yes	❑ No			
Food Collection Between Teeth	❑ Yes	❑ No	Orthodontic Treatment	❑ Yes	❑ No			

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Patient Name _____ Birth Date_____

PERSONAL AUTHORIZATION FORM FOR RELEASE OF MEDICAL INFORMATION

I authorize this facility and staff to speak to the following family members or my personal representative regarding:

All medical information, including but not limited to records pertaining to examination, treatments, consultations, billing records, x-rays, and reports, history, laboratory findings, admissions and discharge reports, treatment records, diagnosis and prognosis and records, assistants, hygienist and doctor's notes and any other non-medical information in my file.

The above medical information shall only be released to the following persons:

Family Member/Personal Representative	**Relationship**

I understand that I may terminate this Medical Authorization form. I must notify **TODAY'S DENTAL** in writing regarding termination and effective date.

This authorization shall remain valid until revoked in writing.

I know that I am entitled to receive a copy of this agreement.

Name _____

Signature _____

Signed this _____ **day of** _____, **20**_____

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FINANCIAL POLICY

Today's Dental is aware that insurance aids in the acceptance of treatment, but should not stand in the way of proceeding with the procedure(s) that are recommended. As a courtesy, we will process insurance claims on your behalf, accepting the assignment of benefits.

We will contact your insurance company to obtain the most accurate coverage of benefits possible. However, quotes are an estimate and could change based upon the payment received from your insurance company.

Payments, deductibles and coinsurance are due at the time services are rendered. For your convenience, we accept credit cards, debit cards, personal checks, cash and money orders. An administrative fee of $30 will apply for all returned checks. We also accept 3rd party financing through CareCredit.

FINANCIAL AGREEMENT/ASSIGNMENT OF BENEFITS/SIGNATURE ON FILE

I agree that in return for services rendered by Today's Dental, I will pay my account at the time services are rendered or will make financial arrangements satisfactory with Today's Dental. I authorize and request my Insurance Company to pay directly to the dentist or dental group. I understand that insurance assignment is accepted for a period not to exceed forty-five days. After that time, I will be responsible for the balance.

I understand that I am financially responsible for any charges not paid by my insurance company. If co-payments/deductibles are designated by my insurance company, I agree to pay them to Today's Dental. Accordingly, I accept full financial responsibility for any services not covered by my insurance benefits. I understand that if my account becomes delinquent, it is subject to professional collections and I will be responsible for all costs, including attorney and court fees.

HIPPA NOTICE OF PRIVACY PRACTICES

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations, such as quality assessments and physician certifications.

I have been given the right to review the full Notice of Privacy Practices prior to signing this consent and may request a copy at any time. I agree to allow electronic communication as defined in security practices effective April 21, 2005.

By signing below, I acknowledge having read, understand and agree to all the information given above.

Patient Name:_____ **Signature:**_____

Relationship to Patient: (Circle One) Self/Parent/Guardian **Date:**_____