Today's DENTAL CARE

PLEASE READ CAREFULLY

We would like to take this opportunity to thank you for choosing Today's Dental Care as your dental health care provider.

Appointments:

We extend our appreciation by respecting you and your valuable time. We strive to keep your wait after check-in to a minimum. We ask that in return, you respect our time. If you are more than 15 minutes late for your reserved time, you may be asked to reschedule.

A 48-hour notice of cancellation must be given in order to avoid a $65 missed appointment fee.

Unfortunately, we cannot accept cancellation notice via voicemail less than 48 hours prior to your appointment. I grant my permission to you or your assignee to telephone me at home or at my workplace to discuss matters related to this form. I also agree to let this office leave messages concerning appointments and/or results on my answering machine or with a family member.

Payments:
We accept cash, personal checks, money orders, cashier's checks, and all major credit cards, except American Express. Payment is due at the time of service. A $25 processing fee will be added to your account for any returned check.

This agreement supersedes all prior agreements signed, including any and all mediation or mediation/arbitrary agreements. I acknowledge that any prior mediation/arbitration agreements signed previously related to financial arrangements or quality of care are null and void.

☐ I authorize the dentist or his designees to release financially identifiable information and treatment descriptions and information, either electronically, by facsimile or in paper form to my insurance carrier or any related entities that require such information to be submitted.

☐ I acknowledge that I have had the opportunity to see and read the Privacy Policies of this office. I agree to disclose to the dentist names of any individuals with whom I authorize the dentist or other staff members to discuss my dental care.

☐ I certify that I have answered all questions on this form accurately and to the best of my knowledge. I hereby agree to abide by the conditions outlined herein. We again thank you for your patronage and cooperation.

I UNDERSTAND AND AGREE TO ABIDE BY THE TERMS OF THIS OFFICE.

Signature: _____ Date: _____

Patient Information

Name _____
Last First Middle Initial Preferred Name

Address _____ City _____ State _____ Zip _____

Date of Birth _____ SSN # _____ Male: ☐ Female: ☐ Married: ☐ Single: ☐ Minor: ☐

Employer _____ Employer phone: _____

Home phone: _____ Cell phone: _____ E-mail: _____

Emergency Contact: _____ Phone: _____ E-mail and text message? ☐ Yes ☐ No

Parent/Guardian Information (if patient is a minor):

Name _____ Relationship to patient _____

Address _____ City _____ State _____ Zip _____

Date of Birth _____ SSN # _____ Driver's License # _____

Home phone: _____ Cell phone: _____ E-mail: _____

Insurance Information

Primary Dental Carrier

Policyholder's Name: _____ Employer: _____

Insurance Company: _____ Group # _____

SSN #: _____ DOB: _____ Patient's Relationship to Policyholder: Self: ☐ Spouse: ☐ Child: ☐ Other: ☐

Secondary Dental Carrier

Policyholder's Name: _____ Employer: _____

Insurance Company: _____ Group # _____

SSN #: _____ DOB: _____ Patient's Relationship to Policyholder: Self: ☐ Spouse: ☐ Child: ☐ Other: ☐

Insurance Authorization Statement (Sign & Date)

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs and dental treatment. I hereby authorize Today's Dental Care of Jerome to release my Protected Health Care Information to Healthcare financing administrations and its agents to determine my healthcare benefits. I hereby authorize Today's Dental Care to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the medical history is correct to the best of my knowledge.

Signature _____ Date _____

Today's DENTAL CARE

Other Information

How did you hear about us? _____

What was the reason for today's visit? _____

Do you love your smile? _____

Is there anything you would like to change? _____

Why did you leave your last Dentist? _____

What did you like most about your last Dentist? _____

Medical History and Information

Have you had, or do you currently have any of the following?

- ☐ Abnormal Bleeding
- ☐ Alcohol Abuse
- ☐ Allergies
- ☐ Anemia
- ☐ Angina Pectoris
- ☐ Arthritis
- ☐ Artificial Heart Valve
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Blood Transfusion
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Colitis
- ☐ Congenital Heart Defect
- ☐ Diabetes
- ☐ Difficulty Breathing
- ☐ Drug Abuse
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Facial Surgery
- ☐ Fainting Spells
- ☐ Fever Blisters
- ☐ Frequent Headaches
- ☐ Glaucoma
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ Heart Surgery
- ☐ Hemophilia
- ☐ Hepatitis A, B, or C
- ☐ High Blood Pressure
- ☐ HIV +, Aids
- ☐ Joint Replacement
- ☐ Kidney Problems
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker
- ☐ Psychiatric Problems
- ☐ Radiation Therapy
- ☐ Rheumatic Fever
- ☐ Seizures
- ☐ Sexually Transmitted Disease
- ☐ Shingles
- ☐ Sickle Cell Disease
- ☐ Sinus Problems
- ☐ Sleep problems (Apnea)
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Other _____

Allergies

- ☐ Aspirin
- ☐ Codeine
- ☐ Erythromycin
- ☐ Dental Anesthetics
- ☐ Other _____
- ☐ Latex
- ☐ Metals
- ☐ Penicillin
- ☐ Sulfa
- ☐ Tetracycline
- ☐ Seasonal

Y	N	
☐	☐	Do you Smoke or use Tobacco?
☐	☐	Have you been told you have periodontal disease/gum disease?
☐	☐	Taking Birth Control Pills?
☐	☐	Are you pregnant? If yes, # of weeks? _____
☐	☐	Are you Nursing?

Please list any medications you are currently taking and further explain any condition: _____

Treatment Authorization Form

I authorize and give consent to perform dental services agreed between doctor and patient and/or parent or guardian necessary or advisable including the use of local anesthesia and other medication as indicated. I certify to the above statements regarding my medical condition. Payment for all treatment and services rendered are my responsibility.

Patient's Signature _____ Date _____

Parent/Guardian Signature _____ Date _____