

# REGISTRATION AND HISTORY

## 1 PATIENT INFORMATION

Date \_\_\_\_\_

SS/HIC/Patient ID # \_\_\_\_\_

Patient Name \_\_\_\_\_  
 Last Name \_\_\_\_\_  
 First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_

E-mail \_\_\_\_\_

Sex  M  F Birthdate \_\_\_\_\_ Age \_\_\_\_\_

Married  Widowed  Single  Minor  
 Separated  Divorced  Partnered for \_\_\_\_\_ years

Occupation \_\_\_\_\_

Patient Employer/School \_\_\_\_\_

Employer/School Address \_\_\_\_\_

Employer/School Phone (\_\_\_\_\_) \_\_\_\_\_

Spouse's Name \_\_\_\_\_

Birthdate \_\_\_\_\_

SS# \_\_\_\_\_

Spouse's Employer \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

## 2 DENTAL INSURANCE

Who is responsible for this account? \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Group # \_\_\_\_\_

Is patient covered by additional insurance?  Yes  No

Subscriber's Name \_\_\_\_\_

Birthdate \_\_\_\_\_ SS# \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Group # \_\_\_\_\_

### ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with \_\_\_\_\_ and assign directly to \_\_\_\_\_  
 Name of Insurance Company(ies)

Dr. \_\_\_\_\_ 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 authorize the use of my signature on all insurance 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. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature of Patient, Parent, Guardian or Personal Representative \_\_\_\_\_

Please print name of Patient, Parent, Guardian or Personal Representative \_\_\_\_\_

Date \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

## 3 PHONE NUMBERS

Home (\_\_\_\_\_) \_\_\_\_\_ Work (\_\_\_\_\_) \_\_\_\_\_ Ext \_\_\_\_\_ Alt. Phone (\_\_\_\_\_) \_\_\_\_\_

Spouse's Work (\_\_\_\_\_) \_\_\_\_\_ Best time and place to reach you \_\_\_\_\_

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Home Phone (\_\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_\_) \_\_\_\_\_

## 4 DENTAL HISTORY

Reason for today's visit _____	Chew on one side of mouth <input type="checkbox"/> Yes <input type="checkbox"/> No	Mouth breathing <input type="checkbox"/> Yes <input type="checkbox"/> No
Former Dentist _____	Cigarette, pipe, or cigar smoking <input type="checkbox"/> Yes <input type="checkbox"/> No	Mouth pain, brushing <input type="checkbox"/> Yes <input type="checkbox"/> No
City/State _____	Clicking or popping jaw <input type="checkbox"/> Yes <input type="checkbox"/> No	Orthodontic treatment <input type="checkbox"/> Yes <input type="checkbox"/> No
Date of last dental visit _____	Dry mouth <input type="checkbox"/> Yes <input type="checkbox"/> No	Pain around ear <input type="checkbox"/> Yes <input type="checkbox"/> No
Date of last dental X-rays _____	Fingernail biting <input type="checkbox"/> Yes <input type="checkbox"/> No	Periodontal treatment <input type="checkbox"/> Yes <input type="checkbox"/> No
Place a mark on "yes" or "no" to indicate if you have had any of the following:	Food collection between the teeth <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to cold <input type="checkbox"/> Yes <input type="checkbox"/> No
Bad breath <input type="checkbox"/> Yes <input type="checkbox"/> No	Foreign objects <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to heat <input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding gums <input type="checkbox"/> Yes <input type="checkbox"/> No	Grinding teeth <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to sweets <input type="checkbox"/> Yes <input type="checkbox"/> No
Blisters on lips or mouth <input type="checkbox"/> Yes <input type="checkbox"/> No	Gums swollen or tender <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity when biting <input type="checkbox"/> Yes <input type="checkbox"/> No
Burning sensation on tongue <input type="checkbox"/> Yes <input type="checkbox"/> No	Jaw pain or tiredness <input type="checkbox"/> Yes <input type="checkbox"/> No	Sores or growths in your mouth <input type="checkbox"/> Yes <input type="checkbox"/> No
	Lip or cheek biting <input type="checkbox"/> Yes <input type="checkbox"/> No	How often do you floss? _____
	Loose teeth or broken fillings <input type="checkbox"/> Yes <input type="checkbox"/> No	How often do you brush? _____

# 5 HEALTH HISTORY

Physician's Name \_\_\_\_\_ Date of last visit \_\_\_\_\_

Have you ever used a bisphosphonate medication? Common brand names are Fosamax, Actonel, Atelvia, Didronel, Boniva.  Yes  No

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dextenfluramine).  Yes  No

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

- |  |  |                       |  |                                 |  |
|--|--|-----------------------|--|---------------------------------|--|
| AIDS/HIV   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Epilepsy              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Respiratory Disease             | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anemia   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Fainting or dizziness | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatic Fever                 | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Arthritis, Rheumatism                            | <input type="checkbox"/> Yes <input type="checkbox"/> No | Glaucoma              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Scarlet Fever                   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Heart Valves                          | <input type="checkbox"/> Yes <input type="checkbox"/> No | Headaches             | <input type="checkbox"/> Yes <input type="checkbox"/> No | Shortness of Breath             | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Joints                                | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Murmur          | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sinus Trouble                   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Problems        | <input type="checkbox"/> Yes <input type="checkbox"/> No | Skin Rash                       | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Back Problems                                    | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis Type _____  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Special Diet                    | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bleeding abnormally, with extractions or surgery | <input type="checkbox"/> Yes <input type="checkbox"/> No | Herpes                | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke                          | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Blood Disease                                    | <input type="checkbox"/> Yes <input type="checkbox"/> No | High Blood Pressure   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Swollen Feet or Ankles          | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Jaundice              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Swollen Neck Glands             | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chemical Dependency                              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Jaw Pain              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid Problems                | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chemotherapy                                     | <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney Disease        | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tonsillitis                     | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Circulatory Problems                             | <input type="checkbox"/> Yes <input type="checkbox"/> No | Liver Disease         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis                    | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Congenital Heart Lesions                         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Low Blood Pressure    | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tumor or growth on head or neck | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cortisone Treatments                             | <input type="checkbox"/> Yes <input type="checkbox"/> No | Mitral Valve Prolapse | <input type="checkbox"/> Yes <input type="checkbox"/> No | Ulcer                           | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cough, persistent or bloody                      | <input type="checkbox"/> Yes <input type="checkbox"/> No | Nervous Problems      | <input type="checkbox"/> Yes <input type="checkbox"/> No | Venereal Disease                | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Diabetes   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pacemaker             | <input type="checkbox"/> Yes <input type="checkbox"/> No | Weight Loss, unexplained        | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Emphysema  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Psychiatric Care      | <input type="checkbox"/> Yes <input type="checkbox"/> No |                                 |  |
|  |  | Radiation Treatment   | <input type="checkbox"/> Yes <input type="checkbox"/> No |                                 |  |

Do you wear contact lenses?  Yes  No

**Women:**

Are you pregnant?  Yes  No Due date \_\_\_\_\_  
 Taking birth control pills?  Yes  No

Are you nursing?  Yes  No

## MEDICATIONS

List any medications you are currently taking and the correlating diagnosis:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Pharmacy Name \_\_\_\_\_

Phone (\_\_\_\_\_) \_\_\_\_\_

## ALLERGIES

- |  |   |
|--|---|
| <input type="checkbox"/> Aspirin                       | <input type="checkbox"/> Local Anesthetic |
| <input type="checkbox"/> Barbiturates (Sleeping-pills) | <input type="checkbox"/> Penicillin       |
| <input type="checkbox"/> Codeine                       | <input type="checkbox"/> Sulfa            |
| <input type="checkbox"/> Iodine                        | <input type="checkbox"/> Other _____      |
| <input type="checkbox"/> Latex                         | _____                                     |

## 0 UPDATES (To be filled in at future appointments)

Has there been any change in your health since your last dental appointment?  Yes  No

For what conditions? \_\_\_\_\_

Are you taking any new medications? \_\_\_\_\_ If so, what? \_\_\_\_\_

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

Doctor's Signature \_\_\_\_\_ Date \_\_\_\_\_

Has there been any change in your health since your last dental appointment?  Yes  No

For what conditions? \_\_\_\_\_

Are you taking any new medications? \_\_\_\_\_ If so, what? \_\_\_\_\_

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

Doctor's Signature \_\_\_\_\_ Date \_\_\_\_\_

## TODAY'S DENTAL FINANCIAL POLICY

Thank you for choosing Today's Dental as your dental care provider. We're committed to your treatment being successful from start to finish. Please understand that payment of your bill is considered part of that treatment.

### FULL PAYMENT IS DUE AT THE TIME OF SERVICE

Cash, Check, Debit Card, VISA, MasterCard, Discover, and American Express are accepted methods of payment. Financial arrangements other than the accepted methods are to be discussed prior to the visit, as approval is required before treatment can begin. We offer financing, where monthly payments can be made, through Care Credit or Chase Healthcare Finance with prior approval. Adult patients and adults accompanying a minor child are responsible for full payment at the time of service.

### RETURNED CHECKS & COLLECTIONS

There will be a \$35.00 charge for bank checks returned for any reason. Patients will be sent three bills indicating their balances. If the account is not paid in full after 3 billing cycles, the account may be turned over to a collection agency. In the event your account has to be turned over to a collection agency, you will be responsible for all administrative fees including any court costs.

### APPOINTMENT POLICY

A charge of \$50-\$100 will be assessed for broken appointments and cancellations without prior notice of 24 hours. A \$100 non-refundable deposit may be required for all appointments of 90 minutes or longer, with a 48-hour minimum notice for cancellation. Saturday appointments may also require a non-refundable deposit.

I have read, understand and agree to this Financial Policy. I have been given the opportunity to discuss questions or concerns with a member of the staff.

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Signature of Responsible Party

Date

## INSURANCE

Assignment of benefits may be accepted only after your insurance has been verified and eligibility requirements have been met. We accept assignment of benefits as a courtesy to you. However, insurance payments are an ESTIMATE based on information obtained from your carrier. There is no guarantee of payment or that they will pay the exact amount estimated. Your estimated co-pay is due at the time of service. Any unpaid balances by the insurance company remain your responsibility. In the event that we are unable to collect on any outstanding insurance claims within 30 days, the balance in full will be billed to you and payment is expected. We require a credit card number and photo ID to be kept on file as a guarantee of payment in the event the insurance company does not pay the balance in full. We may contact you prior to charging your credit card. If you do not have a credit card number we will not be able to accept assignment of benefits. Payment in full is expected in cases where insurance companies will not assign benefits to us but are known to send reimbursements checks directly to the insured. Your insurance policy is a contract between you and your insurance carrier. We are not a party to that contract. Please be aware that some, and perhaps all, of the service provided may be non-covered and not considered reasonable and necessary under various insurance plans. Our practice is committed to providing the best treatment for our patients and we charge a fair fee for the high quality of dentistry that we provide. You are responsible for payment regardless of any insurance company's arbitrary determinations of "usual and customary" fees or need for treatment.

### CREDIT CARD AUTHORIZATION (for patients with insurance):

I hereby authorize payment by credit card for any unpaid balance which exceeds 30 days on my account.

Type of Credit Card \_\_\_\_\_  
Credit Card Number \_\_\_\_\_  
3-digit Number \_\_\_\_\_  
Expiration Date \_\_\_\_\_  
Name (print) \_\_\_\_\_  
Signature \_\_\_\_\_ Date \_\_\_\_\_

# HIPAA Information and Consent Form

Today's Dental, 6030 Park Blvd, Pinellas Park, FL 33781

727.547.6453

The Health Insurance Portability and Accountability Act (HIPAA) provide safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been *our* practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. [www.hhs.gov](http://www.hhs.gov)

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI, and other documents or information.
2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S. mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.
3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.
4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.
5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.
6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods, or services.
7. We agree to provide patients with access to their records in accordance with state and federal laws, and our office policy.
8. We may change, add, delete or modify any of these provisions to better serve the needs of both the practice and the patient.
9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, \_\_\_\_\_ date \_\_\_\_\_ do hereby consent and acknowledge my acknowledgement my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

### COVID 19 Consent

I, \_\_\_\_\_, knowingly and willingly consent to have dental treatment completed during the COVID-19 pandemic. I understand the COVID-19 virus has a long incubation period during which carriers of the virus may not show symptoms and still be highly contagious. It is impossible to determine who has it and who does not give the current limits in virus testing. Dental procedures create water spray. It is unclear as to how long the ultra-fine nature of the spray may linger in the air, which can transmit the COVID-19 virus.

I confirm that I am not presenting any of the following symptoms of COVID-19 listed below:

- Fever • Shortness of Breath • Loss of Sense of Taste or Smell • Dry Cough • Runny Nose • Sore Throat \_\_\_\_\_ (Initial)

Have you been in contact with anyone confirmed with Covid-19?

Yes  No

Have you traveled in the past 14 days?

Yes  No

I understand that because dentistry involves close physical proximity over an extended period of time there may be an elevated risk of disease transmission, including COVID-19.

\_\_\_\_\_ I understand and agree to treatment (initial)

I acknowledge that I am aware of the risk involved from receiving treatment at this time. I voluntarily agree to assume those risks, and I release and hold harmless the practice/business from any claims related thereto.

\_\_\_\_\_ I give my consent for treatment (initial)

Name \_\_\_\_\_ Date \_\_\_\_\_

