Welcome!

Today's Date: _____

□ Male □ Female

Full Legal Name: _____ Preferred Name: _____

Birthdate: _____ Social Security: _____ □ Child □ Single □ Married □ Divorced □ Widowed

Mailing Address: _____ City: _____ Zip Code: _____

Check Preferred: □ Home: (___) _____ □ Cell: (___) _____ □ Work: (____) _____

Referred By: _____ E-Mail Address: _____

Employer: _____ Occupation: _____ Duration: _____

Emergency Contact: _____ Relation: _____ Phone: (___) _____

SPOUSE INFORMATION

Full Name: _____ Birthdate: _____ Phone: _____

PERSON RESPONSIBLE FOR ACCOUNT

Full Name: _____ Relation: _____ Birthdate: _____

Billing Address: _____ City: _____ Zip Code: _____

INSURANCE INFORMATION

Dental Coverage? □ Yes □ No □ Self □ Dependent Secondary Insurance? □ Yes □ No

Insured Party: _____ Social Security: _____

Insurance Co: _____ Phone: _____ Group: _____

Subscriber ID: _____ Insurance Address: _____

Relation (If Not Self): _____ Employer: _____

Medical and Dental History

Please answer all of these questions YES or NO and provide answers where applicable:

1. Do you consider yourself to be in good health? YES NO
2. Are you now, or have been under a physician's care within the last year? YES NO
    a. If so, please specify condition for treatment _____
3. Do you have or have you ever had any heart or blood problems? YES NO
4. Have you ever been told you have a heart murmur? YES NO
5. Do you have or have a history of high blood pressure? YES NO
6. Do you bleed or bruise easily? YES NO
7. Are you subject to fainting? YES NO
8. Have you ever been diagnosed as being HIV positive or having AIDS? YES NO
9. Have you ever had hepatitis or liver disease? YES NO
    a. Specify:_____
10. Have you ever had: Please Circle YES NO
    Ashthma Any Blood Disorder Kidney Disease Diabetes (I or 2)
    Joint Pain/Arthritis Tuberculosis Pneumonia Heart Attack Heart Disease
    Endocarditis Rheumatic Fever Immune System Disorders Other
    If so, please specify: _____
11. Do you take any medication, including birth control pills? YES NO
    a. Please specify name and purpose of medications: _____
    _____
12. Have you ever had an unusual reaction, or are allergic to any of the following drugs? YES NO
    Penicillin Aspirin Acetaminophen Ibuprofen Codeine Barbiturates
    Sulfa Drugs Other: _____
13. Do you require antibiotic pre-medication for a heart condition or artificial valve? YES NO
14. Have you ever taken: Fosamax, Boniva, Actamel or any other drug affiliated with osteoporosis? YES NO
15. Have you ever used or are you now using tobacco or alcohol? YES NO
16. Is there any family history of substance abuse or misuse? YES NO
17. Is there any personal history of substance abuse of misuse? YES NO
18. Have you ever received counseling for use of alcohol and or prescription drugs? YES NO
19. Do you take any sedative medication, including herbal supplements? YES NO
20. Do you have any other allergies? Please Specify: _____ YES NO
21. Have you ever had a nervous breakdown or undergone psychiatric treatment? YES NO
22. **WOMEN**: Are you pregnant? Of suspect of being pregnant? YES NO
23. Are you now in pain? YES NO
24. How long ago did you see a dentist? _____
25. Who was your previous dentist? _____
26. Do you think that your teeth are affecting your general health in any way? YES NO
27. Have you ever had any severe reaction to dental treatment or local anesthetics? YES NO
28. Are you allergic to any local anesthetic? YES NO
29. Do you have or have you ever had bleeding or sensitive gums? YES NO
    a. If yes, have you seen your physician or cardiologist for a cardiac evaluation? YES NO

I HEREBY CERTIFY THAT THE ANSWERS TO THE FOREGOING QUESTIONS ARE ACCURATE TO THE BEST OF MY ABILITY. I UNDERSTAND A CHANGE IN MY MEDICAL HISTORY, OR IN PERSCRIBED MEDICATIONS CAN AFFECT DENTAL TREATMENT, I UNDERSTAND THE IMPORTANCE OF AND AGREE TO TAKE RESPONSIBILITY TO NOTIFY THE DENTIST OF ANY CHANGES AT ANY SUBSEQUENT APPOINTMENT.

Signature: _____ Date: ___/___/_____

OFFICE POLICY

I understand that the administration of local anesthetic may cause an untoward reaction or side effects, which may include, but are not limited to, bruising, hematoma, cardiac stimulation, and temporary or rarely, permanent numbness, and muscle soreness. I understand that occasionally needles break and may require surgical retrieval.

I do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, in any, which may be associated with general preventative and operative treatment procedures in hopes of obtaining the potential desired results which may or may not be achieved, for my benefit or the benefit of my minor child or ward. I acknowledge that the nature and purpose of the foregoing procedures have been explained to me if necessary and I have been given the opportunity to ask questions.

Signature _____ Date____/_____/_____
(Patient, legal guardian, or authorized agent of patient)

FINANCIAL AGREEMENT

For services in this office, the undersigned agrees to pay the amount charged for professional treatment and services to the undersigned and person whose name appears below on the agreement, including any unlisted spouse and dependent.

I agree to pay at the time of service or to make arrangements for payment.

I understand that if I fail to repay as agreed, legal action could be taken against me. I agree to pay any costs incurred in the collection process of this plan including, but not limited to, late fees, attorney's fees, charges or commissions up to 50% that may be assessed by a collection agency retained to pursue this matter, with or without suit. I further agree to pay interest at the rate of 1.5% per month (18% per year) on any amount over 90 days past due.

Signature _____ Date____/_____/_____

Witness _____

Written Financial Policy

Thank you for choosing Richard L. Ellis, II, D.M.D., Richard L. Ellis, III, D.D.S.. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:

You can choose from:

- Cash, Check, Visa, Mastercard or Discover Card

We offer a 10% courtesy accounting adjustment to patients who pay for their treatment with cash or check prior to completion of care.

- NO INTEREST[1] Payment Plans[2] from CareCredit
    - Allow you to pay over time with NO INTEREST[1]
    - Convenient, low monthly payment plans[2] also available
    - No annual fees or pre-payment penalties

Please note:

Richard L. Ellis, II, D.M.D., Richard L. Ellis, III, D.D.S. requires payment prior to the completion of your treatment. If you choose to discontinue care before treatment is complete, your refund will be determined upon review of your case.

We accept payment in thirds. For plans requiring more than 3 appointments, alternative payment arrangements may be provided.

We also offer in-house financing. We charge 1.5% interest on all past due accounts.

For patients with dental insurance we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment.

A fee of $50 is charged for patients who miss or cancel more than 2 times in a calendar year without 24-hour notice.

Richard L. Ellis, II, D.M.D., Richard L. Ellis, III, D.D.S. charges $30 for returned checks.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

_____

Patient, Parent or Guardian Signature Date

_____

Patient Name (Please Print)

[1]If paid within the promotional period. Otherwise, interest assessed from purchase date. Minimum monthly payment required.

[2]Subject to credit approval

[3]However, if we do not receive payment from your insurance carrier within 90 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.