

PATIENT INFORMATION

DATE _____

PATIENT NAME _____ DATE OF BIRTH _____

PARENT(S)/GUARDIAN NAME _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE _____ EMERGENCY CONTACT _____ PHONE _____

PERSON RESPONSIBLE FOR ACCOUNT ☐ FATHER ☐ MOTHER ☐ GUARDIAN ☐ OTHER _____

INSURANCE INFORMATION

PRIMARY INSURED _____ HM PHONE _____ WK PHONE _____

ADDRESS _____

EMPLOYER _____ SS# _____ BIRTHDATE _____

PLAN NAME _____ GROUP # _____ POLICY # _____

DENTAL HISTORY

DATE OF LAST VISIT TO DENTIST _____ PREVIOUS DENTIST _____

HAS CHILD COMPLAINED OF ANY DENTAL PROBLEMS? NO YES ANY INJURIES TO MOUTH OR TEETH? NO YES

HOW OFTEN DOES CHILD: BRUSH? _____ FLOSS? _____

DOES CHILD USE FLUORIDE DROPS OR TABLETS? NO YES ANY UNHAPPY DENTAL EXPERIENCES? NO YES

MEDICAL HISTORY

CHILD'S PHYSICIAN _____ PHONE _____

TAKING ANY MEDICATIONS? _____

ANY ALLERGIES TO MEDICATIONS? _____

EVER HAD A SURGERY OR HOSPITALIZATION? _____

ANY PROBLEMS WITH THE FOLLOWING:

- | | | | | |
|---|--|--------------------------------------|-----------------------------------|-----------------------------------|
| ☐ HEART PROBLEMS | ☐ RHEUMATIC FEVER | ☐ ANEMIA | ☐ ASTHMA | ☐ CANCER |
| ☐ KIDNEY DISEASE | ☐ EPILEPSY/SEIZURES | ☐ HEPATITIS | ☐ DIABETES | ☐ HIV/AIDS |
| ☐ LIVER PROBLEMS | ☐ TUBERCULOSIS | ☐ OTHER _____ | | |

DOCTOR'S SIGNATURE _____ DATE _____

AUTHORIZATION

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO ELLIS DENTISTRY OF THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL COSTS OF DENTAL TREATMENT. I HEREBY AUTHORIZE ELLIS DENTISTRY TO ADMINISTER SUCH MEDICATIONS AND PERFORM SUCH DIAGNOSTIC, PHOTOGRAPHIC AND THERAPEUTIC PROCEDURES AS MAY BE NECESSARY FOR PROPER DENTAL CARE. THE INFORMATION ON THIS PAGE AND THE DENTAL/MEDICAL HISTORIES ARE CORRECT TO THE BEST OF MY KNOWLEDGE. I GRANT THE RIGHT TO THE DENTIST TO RELEASE MY DENTAL/MEDICAL HISTORIES AND OTHER INFORMATION ABOUT MY DENTAL TREATMENT TO THIRD PARTY PAYORS AND/OR OTHER HEALTH PROFESSIONALS.

PARENT/GUARDIAN SIGNATURE _____ DATE _____

Welcome to our office! The doctor and staff are dedicated to providing you with the highest quality dental care in a comfortable, caring environment. Our goal is to help you achieve optimum oral health. To help us manage the office in a professional and efficient manner please be aware of the following office policies:

Appointments

While we make every effort to give a reminder call the day before your visit, it is your responsibility to show up for scheduled appointments. A missed appointment is a missed opportunity for another patient to receive care. **A \$75 per hour fee is charged for missed appointments.** Repeated missed appointments will result in dismissal from the practice.

Please contact our office at least **24 hours in advance to cancel or change an appointment.**

Payment

It is your payment that allows us to maintain our business, provide high levels of professional care, and pay our staff. We require **payment on the day of service.**

Our office will bill your insurance as a service to you. However, you are responsible for the payment of the entire fee should the insurance company deny benefits. **We are not able to guarantee insurance benefit estimates**, even if predetermination has been made.

Cash, check, or credit cards are accepted. Low interest, and no interest payment plans are also available on approval of credit.

Returned checks will be charged a **\$25 NSF fee.** If unpaid, a returned check will be turned over to the Whatcom County Prosecutor.

Treatment Plans

Treatment quotes are honored for 90 days. Please be aware that they are **estimates only** and that your treatment can change as your case proceeds due to the dynamics of your oral health, especially if you delay treatment. Some examples are: the need for root canal therapy following a filling or crown, or the need for a larger filling than anticipated. We will discuss changes with you as they arise.

Sedation

State law requires us to follow stringent requirements for sedating patients during dental treatment. Sedating yourself prior to a dental appointment with alcohol, sedatives, narcotics, or other drugs is not permitted.

Patient Signature _____ **Date** _____