ellis|dentistry

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting Ellis Dentistry at 360.592.1100

Our **Notice of Privacy Practices** describes in more detail how your health information may be used and disclosed, and how you can access your information.

By my signature below I acknowledge receipt of the Notice of Privacy Practices.

Patient or legally authorized individual signature

Date

Printed Name if signed on behalf of the patient

Relationship
(parent, legal guardian, personal representative)

This form will be retained in your medical record.

ellis|dentistry

PATIENT NAME_____ DATE_____

DENTAL HISTORY

Do you have a *specific* dental concern? No Yes Describe: _____

Are you apprehensive about receiving dental treatment? No Yes Explain, _____

How long since your last dental visit? _____Where? (optional) _____

How long since your last cleaning? _____ Have you ever been diagnosed with periodontal disease? No Yes

Do you have any of the following problems?

- ❑ Does food catch between your teeth?
- ❑ Do you have pain or swelling?
- ❑ Do you have difficulty chewing food?
- ❑ Do you clench or grind?
- ❑ Are your teeth sensitive to hot or cold?
- ❑ Have you had a jaw injury?
- ❑ Do you have frequent headaches?
- ❑ Do your gums bleed easily?

How often do you brush? _____

How often do you floss? _____

HEALTH HISTORY

Please list the names and phone numbers of any physicians who are currently providing you care: _____

_____

_____

Have you been hospitalized in the last 5 years? No Yes, reason:_____

_____

Do you have or have you ever had any of the following conditions:

Artificial Heart Valve	No	Yes	Emphysema/ COPD	No	Yes	Kidney Problems	No	Yes
Endocarditis	No	Yes	Tuberculosis	No	Yes	Hepatitis	No	Yes
Heart Attack/ Stroke	No	Yes	Cancer: (type)_____	No	Yes	Liver Problems	No	Yes
Angina/Chest pain	No	Yes	Radiation Treatments	No	Yes	Stroke	No	Yes
Congenital Heart Defect	No	Yes	Chemotherapy	No	Yes	Anemia	No	Yes
Heart Transplant	No	Yes	Diabetes: type 1 or 2?	No	Yes	Asthma	No	Yes
Pacemaker	No	Yes	Hypoglycemia	No	Yes	Psychiatric Care	No	Yes
High Blood Pressure	No	Yes	Cold Sores/Fever Blisters	No	Yes	Sinus Trouble	No	Yes
Other Heart Problem	No	Yes	Epilepsy or Seizures	No	Yes	Glaucoma	No	Yes
Arthritis or Joint disease	No	Yes	HIV Positive or AIDS	No	Yes	Joint Replacement	No	Yes
Enlarged Lymph Nodes	No	Yes	Drug Addiction/ Alcoholism	No	Yes	Abnormal Bleeding	No	Yes

Are you allergic to or have you had a reaction to:

- ❑ Novocaine or other local anesthetics No Yes
- ❑ Penicillin or other antibiotics..... No Yes
- ❑ Ibuprofen, Acetaminophen or Aspirin No Yes
- ❑ Vicodin, or other pain medications... No Yes
- ❑ Valium or other sedatives ..... No Yes
- ❑ Latex Rubber ..... No Yes
- ❑ Metals ..... No Yes
- ❑ Other _____

Women: Are you pregnant?	No	Yes
Are you trying to become pregnant?	No	Yes
Are you a nursing mother?	No	Yes
Are you using birth control pills?	No	Yes
Have you reached menopause?	No	Yes

Do you have any other medical condition we should know about?

_____

_____

_____

Please list any current medications you are taking and why you are taking them: _____

_____

_____

Are you required to Pre-Medicate with antibiotics before dental treatment? No Yes

Do you smoke or use smokeless tobacco? No Yes If yes, how much per day? _____How many years? _____

Do you drink alcohol? No Yes If yes, how much? ❑Occasional ❑Moderate ❑Heavy How many years? _____

What is your usual sugar intake? : ❑ None ❑ Slight ❑ Moderate ❑ High

Have you ever taken any of the following bone medications? No Yes ❑Aredia/Zometa ❑Fosamax ❑ Actinol

Patient's or Parent's (if patient is a minor) Signature _____ Date _____

DOCTOR'S USE ONLY

Reviewed by Doctor _____ Date _____ BP _____

Notes: _____

ellis|dentistry

OFFICE POLICIES

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.

Lorem Ipsum

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** _____

ellis|dentistry

PATIENT INFORMATION

PATIENT NAME _____ ❑MARRIED ❑SINGLE ❑MINOR ❑MALE ❑FEMALE

DATE OF BIRTH _____ IF A MINOR, PARENT'S NAME _____

MAILING ADDRESS _____ CITY _____ STATE _____ ZIP _____

CELL PHONE _____ WORK PHONE _____

SOCIAL SECURITY # _____

NAME OF EMPLOYER _____ PHONE # _____

E-MAIL ADDRESS _____

YOUR PREFERRED METHOD OF CONTACT FOR CONFIRMING APPOINTMENTS
❑ PHONE CALL ❑ TEXT MESSAGE ❑ E-MAIL

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

PERSON TO CONTACT IN CASE OF EMERGENCY _____ PHONE _____

DENTAL INSURANCE INFORMATION

PRIMARY DENTAL INSURANCE (write "same" if item is same as above)

SUBSCRIBER NAME (If different from patient) _____

SUBSCRIBER BIRTHDATE _____

SUBSCRIBER RELATIONSHIP TO PATIENT ❑ Self ❑ Spouse/Domestic Partner ❑ Parent/Guardian

SUBSCRIBER EMPLOYER _____

DENTAL INSURANCE COMPANY _____

DENTAL INSURANCE COMPANY ADDRESS _____

SUBSCRIBER/MEMBER # (may be SSN of subscriber) _____

INSURANCE COMPANY PHONE # _____

If you have a secondary dental insurance company please provide us with that information below:

_____

_____

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.

PATIENT SIGNATURE _____ DATE _____