ADULT PATIENT - REGISTRATION

Patient's name _____ Birth date _____
First Middle Last

Street Address _____

City _____ State _____ Zip _____ Land Phone _____

Patient Cell Phone _____ Patient Work Phone _____ Ext _____

Patient e-mail address: _____

Patient employed by: _____ Social Security # _____

Name of spouse/partner _____ Birth date _____

Spouse Cell Phone _____ Spouse Work Phone _____ Ext _____

Spouse/partner employed by: _____ Social Security # _____

Contacts in case of emergency (not yourself or spouse):

Name: _____ Relationship: _____ Phone: _____ Cell: _____

Name: _____ Relationship: _____ Phone: _____ Cell: _____

INSURANCE:

Insurance Company _____ Employer _____

Policy Holder's name _____ Date of Birth _____

Policy/Contract No. _____ Group No. _____

2nd Insurance Company _____ Employer _____

Policy Holder's name _____ Date of Birth _____

Policy/Contract No. _____ Group No. _____

Please be prepared to provide for duplication: 1. Current Photo I.D. 2. Insurance cards (if applicable)

Whom may we thank for referring you to our office: _____

The undersigned agree(s) that in the event of default or that the account is placed with a collection agency for collection, he/she is responsible for reasonable attorney's fees, miscellaneous costs of collection, collection agency fees, court costs, service charges and/or interest as allowed by law.

Patient Signature: _____ Date _____

Updated: _____ *Ini* _____ *Updated:* _____ *Ini* _____ *Updated:* _____ *Ini* _____

Updated: _____ *Ini* _____

Entered by: _____ *Checked by:* _____

HEALTH HISTORY

Correct answers to the following questions will allow your dentist to treat you on a more individual basis, providing the care appropriate for your particular needs.

Name _____ Birth date _____ Age _____

Why are you now seeking dental treatment? _____

Please answer each question. Check yes or no. If in doubt, leave blank.

	YES	NO
1. Are you in good health now?	☐	☐
2. Are you now under the care of a physician?	☐	☐
If so, what is the condition being treated? _____		
3. Have you ever been hospitalized or had a serious illness?	☐	☐
If yes, explain _____		
4. Have you ever had excessive bleeding following an extraction, or do cuts take longer to heal now than previously?	☐	☐
5. (Women) Are you pregnant? If so, give due date _____	☐	☐
6. Do you use tobacco in any form? If yes, how much _____	☐	☐
7. Do you use alcoholic beverages (more than 2 drinks per day)?	☐	☐

8. Do you have or have you ever had any of the following?

GENERAL	YES	NO
Tire easily, weakness	☐	☐
Marked weight change	☐	☐
Night sweats	☐	☐
Persistent fever	☐	☐
SKIN		
Eruptions (rash) hives	☐	☐
Change in skin color	☐	☐
EYES		
Visual change	☐	☐
Glaucoma	☐	☐
EARS		
Loss of hearing	☐	☐
Ringing in ears	☐	☐
NOSE		
Frequent nosebleeds	☐	☐
Sinus problems	☐	☐
THROAT		
Soreness/hoarseness	☐	☐
NERVOUS SYSTEM		
Stroke	☐	☐
Headaches	☐	☐
Convulsions/epilepsy	☐	☐
Numbness/tingling	☐	☐
Dizziness/fainting	☐	☐
Psychiatric treatment	☐	☐
RESPIRATORY		
Tuberculosis	☐	☐
Emphysema	☐	☐
Asthma/hay fever	☐	☐
Persistent cough	☐	☐
Sputum production (phlegm)	☐	☐
Cough up bloody sputum	☐	☐
Difficulty breathing while lying down	☐	☐
ENDOCRINE		
Diabetes	☐	☐
Family history of diabetes	☐	☐
Thyroid condition/goiter	☐	☐
Other	☐	☐

HEART/BLOOD VESSELS	YES	NO
Rheumatic fever	☐	☐
Heart murmur	☐	☐
Chest pain/discomfort	☐	☐
Heart attack/trouble	☐	☐
Shortness of breath	☐	☐
Swelling of ankles	☐	☐
High blood pressure	☐	☐
Congenital heart disease	☐	☐
Mitral valve prolapse	☐	☐
Artificial heart valve	☐	☐
Pacemaker	☐	☐
Heart surgery	☐	☐
Other	☐	☐
BONE/MUSCLES		
Arthritis/rheumatism	☐	☐
Artificial joints/limbs	☐	☐
DIGESTIVE SYSTEM		
Hepatitis	☐	☐
Jaundice	☐	☐
Ulcers	☐	☐
Change in appetite	☐	☐
Black, bloody or pale stools	☐	☐
URINARY		
Kidney disease	☐	☐
Increase in frequency of urination (night)	☐	☐
Burning on urination	☐	☐
Urethral discharge	☐	☐
Bloody urine	☐	☐
Venereal disease	☐	☐
BLOOD		
Bruise easily	☐	☐
Anemia	☐	☐
Blood transfusion	☐	☐
OTHER		
Latex sensitivity	☐	☐
Radiation therapy	☐	☐
Chemotherapy	☐	☐
Tumors or growths	☐	☐
Cancer	☐	☐
HIV+	☐	☐
AIDS	☐	☐
Eating disorder	☐	☐

Please complete reverse side

9. Are you ALLERGIC or have you ever experienced any reaction to the following?

	YES	NO		YES	NO
Local anesthetics (e.g. novocaine)	☐	☐	Aspirin or codeine	☐	☐
Barbiturates/sedatives/sleeping pills	☐	☐	Sulfa drugs	☐	☐
Penicillin/other antibiotics	☐	☐	Other allergies _____		

10. Are you taking any of the following?

	YES	NO		YES	NO
Antibiotics/sulfa drugs	☐	☐	Tranquilizers	☐	☐
Blood thinners	☐	☐	Herbal supplements	☐	☐
Blood pressure medication	☐	☐	Insulin/other diabetes drugs	☐	☐
Thyroid medication	☐	☐	Recreational drugs	☐	☐
Cortisone/steroids	☐	☐	Digitalis/other heart medications	☐	☐
Antihistamines/allergy drugs/	☐	☐	Nitroglycerin	☐	☐
Pain medication	☐	☐	Aspirin	☐	☐

If yes to any of the above, list name of medication and dosage below:

1. _____
2. _____
3. _____
4. _____

11. Is there any disease, condition or problem not listed above that you think we should know about, or is there any activity your doctor says you cannot do? If so, explain _____

_____

12. Physician's Name _____ Phone _____

13. Have you ever had any serious trouble associated with previous dental treatment? _____

_____

14. Does dental treatment make you nervous? No _____ Slightly _____ Moderately _____ Extremely _____

15. Date of last dental visit _____

16. Have you ever been treated for periodontal disease (gum disease, pyorrhea, trench mouth)? _____

If so, when? _____

17. Do you have or have you ever had any of the following?

MOUTH

	YES	NO
Bleeding, sore gums	☐	☐
Unpleasant taste/bad breath	☐	☐
Frequent blisters, lips/mouth	☐	☐
Burning tongue/lips	☐	☐
Swelling/lumps in mouth	☐	☐
Ortho treatments (braces)	☐	☐
Biting cheeks/lips	☐	☐
Clicking/popping jaw	☐	☐
Difficulty opening or closing jaw	☐	☐

MOUTH

	YES	NO
Loose teeth	☐	☐
Sensitive to hot	☐	☐
Sensitive to cold	☐	☐
Sensitive to sweets	☐	☐
Sensitive to biting	☐	☐
Food impaction	☐	☐
Clenching/grinding	☐	☐
Shifting of teeth	☐	☐
Change in bite	☐	☐

ORAL HYGIENE

Do you use the following?	YES	NO
Brush	☐	☐
Dental floss	☐	☐
Fluoride rinse	☐	☐
Other _____		

How often do you brush? _____

Brush is: Soft ☐ Medium ☐ Hard ☐

To the best of my knowledge, all of the preceding answers are true and correct.

If I ever have any change in my health or change in my medication, I will inform the dentist at the next appointment.

Signature of Patient
Parent, or Guardian _____ Date _____

Consent to the Use and Disclosure of Health Information for Treatment, Payment or Healthcare Operations

K. CLAY ELLIS, JR., DMD, LLC

I understand that as part of my dental care, K. Clay Ellis, Jr., DMD originates and maintains health records describing my health history, examination and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves as:

A basis for planning my care and treatment
A means of communication among other health professionals who contribute to my care
A source of information for applying my treatment information to my bill
A means by which a third-party payer can verify that services billed were actually provided
And a tool for routine dental care operations such as quality assessment and improvement activities

I understand and have been informed of my dental provider's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices*. I understand that my dental provider has the right to change the *Notice of Privacy Practices* and that I may contact this office to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations and that K. Clay Ellis, Jr. is not required to agree to the restrictions requested. I understand that I may revoke this restriction in writing, except to the extent that K. Clay Ellis has already taken action in reliance thereon.

_____ _____

Signature of Patient or Legal Representative Date

Acknowledgement of Receipt of Notice of Privacy Practices

K. Clay Ellis, Jr., DMD, LLC

You may refuse to sign this acknowledgement

By signing this form I acknowledge that I have been provided with this office's Notice of Privacy Practices to review, and informed that I may keep a copy for reference or obtain a copy upon request.

Print Name: _____

Signature: _____ Date: _____

For Office Use Only:

We attempted to obtain written acknowledgement, but it could not be obtained because:

____ The patient refused to sign
____ Communication barriers
____ Emergency situation
____ Other _____

K. CLAY ELLIS, JR., DMD, LLC

Patient Financial and Insurance Agreement

Welcome to our office. We are honored that you have chosen us as your dental health care provider.

Quality dental care is a financial investment. If you have insurance benefits, we will work with you to help you understand and maximize your coverage. Insurance companies and coverage can vary. Your contract for insurance benefits exists between you and your insurance carrier.

Please remember that you are ultimately responsible for your account with our office.

1. All payments are due at the time service is rendered. We accept payment for services by cash, check, debit, MasterCard, Visa, American Express, Discover, and Care Credit.
2. If you have dental insurance, we will be happy to file your claim(s) for you as a courtesy. Ultimately, what insurance does not cover is the responsibility of the patient.
3. If your insurance does not cover 100% of the charges, you are responsible for the non-covered balance. You will receive an estimate of your liability prior to any appointments so that you will be financially prepared. Please remember that, regardless of insurance coverage, you are responsible for your account with our office.
4. When treatment is rendered, our staff will fully brief you on the costs and ask that your estimated co-payment and deductible be paid at the time of service. We may require a deposit at the time of appointment for some services that cost more than $200. Our office will let you know of any required deposit in advance. We will file insurance claims and accept assignment of benefits. After receiving payment through your insurance, we will send a statement with any balances due. We ask that payment be made within 14 days of the statement.
5. If you do not have insurance, or your insurance reimburses you, or you are over your insurance limit, payment in full is expected at the time of service unless arrangements have been made in writing prior to treatment.
6. Fees quoted will be accepted for 90 days. In the event that clinical conditions warrant a different treatment, you will be notified of changes prior to the procedure.
7. In the event of default of payment or after 90 days, a service charge of 1.5 percent per month will be added to any outstanding balances not paid within 30 days of the current monthly billing statement. All accounts in which effort to pay is not made will be subject to collection proceedings.
8. Our office requires a 24-hour notice for any cancelled appointments. A fee of $50 may be assessed for canceling an appointment without 24-hour notice.

Thank you for reviewing our financial and insurance policy. We will make every effort to explain your costs to you before treatment so we can avoid misunderstandings and focus on your dental health. If you have any questions, please ask—we are here to serve you.

I have read, understand, and agree to abide by this policy. I have been given the opportunity to receive a copy of this document.

_____

PRINT Patient Name

_____ _____

Signature of Patient or Parent if Minor Date

Disclosure of Protected Health Information - PRIVACY

{Sharing Protected Health Information with Family and Friends}

By law, medical information is confidential unless written authorization is given. Therefore, upon signing this form, I am authorizing **K. Clay Ellis, Jr., DMD, and staff** to discuss my medical information with the following individuals:

Name - PLEASE PRINT	Relationship	Phone Number
1._____	_____	_____
2._____	_____	_____
3._____	_____	_____
4._____	_____	_____

***OR** Do **not** disclose medical information to anyone other than myself _____ (initials)

Besides calling me on my personal phone numbers or mailing correspondence to my home, this authorization also allows Dr. Ellis or his staff to do the following:

- Call me at work
- Leave messages on an answering machine or voice mail
- Send Text messages
- Email appointment reminders or other correspondence
- Discuss appointments & account with the above individuals

This remains in effect until I give written notification to change it or discontinue it.

_____ _____

Signature of Patient or Legal Representative: Date:

As Required by Federal Law:

I certify I am who I claim to be.

I have provided documentation supporting claims and my information was verified by: _____

It will be my responsibility to inform of any changes in my personal information upon future visits.

_____

Signature of Patient or Legal Representative: Date:

FOR OFFICE USE ONLY

I have followed regulations in obtaining, verifying, and recording this patient's identification.

Staff Signature: _____ Date:_____