

# WELCOME

## PATIENT INFORMATION

DATE \_\_\_\_\_

PATIENT'S LAST NAME \_\_\_\_\_ FIRST \_\_\_\_\_ MIDDLE \_\_\_\_\_

PREFERRED NAME \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_ BIRTHDATE \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_

HOME PHONE \_\_\_\_\_ CELL PHONE \_\_\_\_\_ EMAIL \_\_\_\_\_

SOCIAL SECURITY # \_\_\_\_\_

EMPLOYER \_\_\_\_\_ WK PHONE \_\_\_\_\_ OCCUPATION \_\_\_\_\_

EMERGENCY CONTACT \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

ADDRESS \_\_\_\_\_ PHONE# \_\_\_\_\_

HOW DID YOU HEAR ABOUT OUR OFFICE? \_\_\_\_\_

SPOUSE'S NAME \_\_\_\_\_ BIRTHDATE \_\_\_\_\_

SOCIAL SECURITY # \_\_\_\_\_ WORK PHONE \_\_\_\_\_

EMPLOYER \_\_\_\_\_ OCCUPATION \_\_\_\_\_ # YRS EMPLOYED \_\_\_\_\_

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## ADULT TREATMENT RELEASE

I GIVE MY PERMISSION TO DR. STEVEN P. ELLINWOOD AND/OR HIS STAFF TO PERFORM ANY AND ALL DENTAL TECHNIQUES AND PROCEDURES, INCLUDING BUT NOT LIMITED TO THE ADMINISTRATION OF NITROUS OXIDE SEDATION AND ANESTHETICS. THIS RELEASE IS VALID UNTIL EXPRESSLY REVOKED. I FURTHER AGREE TO BE FINANCIALLY RESPONSIBLE FOR ALL TREATMENT RENDERED. I ALSO AGREE TO BE RESPONSIBLE FOR ALL COLLECTION COSTS IN THE EVENT OF NONPAYMENT, INCLUDING ATTORNEY FEES.

SIGNED \_\_\_\_\_ WITNESS \_\_\_\_\_ DATE \_\_\_\_\_

**PLEASE COMPLETE OTHER SIDE**

# DENTAL INSURANCE INFORMATION

INSURED'S NAME \_\_\_\_\_ INSURED'S SOC. SEC. # \_\_\_\_\_

PRIMARY INSURANCE COMPANY \_\_\_\_\_ GROUP # \_\_\_\_\_

INSURANCE CO.  
ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

INSURANCE CO. PHONE # \_\_\_\_\_

SECONDARY INSURANCE SUBSCRIBER \_\_\_\_\_ BIRTHDATE \_\_\_\_\_

INSURED'S SOCIAL SECURITY # \_\_\_\_\_ RELATIONSHIP TO PATIENT \_\_\_\_\_

SECONDARY INSURANCE COMPANY \_\_\_\_\_ GROUP # \_\_\_\_\_

SECONDARY INS. CO. ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

SECONDARY INS. CO. PHONE # \_\_\_\_\_

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## SIGNATURE ON FILE

THE UNDERSIGNED HEREBY AUTHORIZES THE RELEASE OF ANY INFORMATION RELATING TO ALL CLAIMS FOR BENEFITS SUBMITTED ON BEHALF OF MYSELF AND/OR DEPENDENTS. I FURTHER EXPRESSLY AGREE AND ACKNOWLEDGE THAT MY SIGNATURE ON THIS DOCUMENT AUTHORIZES MY DENTIST TO SUBMIT CLAIMS FOR BENEFITS, FOR SERVICES RENDERED OR FOR SERVICES TO BE RENDERED, WITHOUT OBTAINING MY SIGNATURE ON EACH AND EVERY CLAIM TO BE SUBMITTED FOR MYSELF AND/OR DEPENDENTS, AND THAT I WILL BE BOUND BY THIS SIGNATURE AS THOUGH I, THE UNDERSIGNED HAD PERSONALLY SIGNED THE PARTICULAR CLAIM. I, \_\_\_\_\_ (NAME OF INSURED), HEREBY AUTHORIZE MY PRESENT INSURANCE COMPANY TO PAY AND HEREBY ASSIGN PAYMENT DIRECTLY TO DR. STEVEN P. ELLINWOOD ALL DENTAL BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR SERVICES AS DESCRIBED ON THE ATTACHED FORMS. I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES INCURRED, LESS ANY DENTAL INSURANCE BENEFITS, WHEN RECEIVED BY AND PAID TO DR. STEVEN P. ELLINWOOD. AUTHORIZATION IS HEREBY GIVEN TO RELEASE ALL INFORMATION NECESSARY TO THE PAYMENT OF SAID BENEFITS.

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(AUTHORIZED SIGNATURE OF COVERED PERSON/EMPLOYEE)

(DATE)