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___

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 #_____

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.

(AUTHORIZED SIGNATURE OF COVERED PERSON/EMPLOYEE) (DATE)