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)

HEALTH HISTORY

Name _____ Date _____

Date of last health care exam: _____What was this exam for?_____

Have you been hospitalized in the last 5 years? (Please circle) No Yes

If yes, reason:_____

Are you currently receiving care? No Yes If yes, nature of care: _____

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

1. _____
2. _____
3. _____

For the following questions circle yes or no. Your answers are for our records only and will be confidential. Please note that during your initial visit you will be asked some questions about your response. Our team may ask additional questions concerning your health.

Heart Murmur (mitral valve prolapse)	No	Yes	Psychosis	No	Yes
Anemia	No	Yes	Sore/Enlarged Lymph Nodes	No	Yes
Diabetes	No	Yes	Previous Biopsies	No	Yes
Epilepsy	No	Yes	Slow-Healing Mouth Sores	No	Yes
Hepatitis, Any Form	No	Yes	Other Infections	No	Yes
Rheumatic Fever	No	Yes	Recurrent Illnesses	No	Yes
Asthma	No	Yes	Joint Replacement	No	Yes
HIV Positive or AIDS Related Complex	No	Yes	Glaucoma	No	Yes
Emphysema or other Respiratory Illnesses	No	Yes	Abnormal Bleeding from a cut	No	Yes
Abnormal Heart or Previous Endocarditis	No	Yes	Liver Disease (including Jaundice)	No	Yes
Heart Disease/ Surgery/Attack/ Stent Placed	No	Yes	Unintentional Weight Loss/Gain	No	Yes
Kidney Disease	No	Yes	Latex Sensitivity	No	Yes
Venereal Disease	No	Yes	Sleep Apnea	No	Yes
Tuberculosis	No	Yes			

Do you have a medical need for pre-medication for dental treatment? No Yes

Women: Are you pregnant? No Yes
If no, are you planning a pregnancy in the near future? No Yes
Are you a nursing mother? No Yes
Are you taking any form of birth control? (pills, patch or implant) No Yes

Abnormal Blood Pressure? (Please circle) No Yes
If yes, what is it usually: _____/_____

Are you allergic or have you had a reaction to:

a. Local anesthetics ……... No Yes
b. Penicillin or other antibiotics …… No Yes
c. Aspirin ……..……... No Yes
d. Codeine, valium or other sedatives……..… No Yes
e. Other _____

Have you traveled outside of the US in the last 30 days? No Yes
If "yes" where _____

Are you a smoker? User of smokeless tobacco (chewing tobacco)? No Yes
If so, how much do you smoke / use per day? _____

Please list any medications you are currently taking and dosages:

1. _____ 2. _____

3. _____ 4. _____

5. _____ 6. _____

Do you consume grapefruit juice, grapefruits or grapefruit extract? No Yes

Are you taking Tagamet (Cimetidine)? No Yes If yes, how often? _____

Do you take Antacids? No Yes If yes, how often? _____

Are you taking any herbal supplements/medicines? No Yes If yes, which ones?_____

Diet: Restricted Diet _____
How many meals a day _____
Food Allergies _____
Sugar in your diet: ❑ None ❑ Slight ❑ Moderate ❑ High

Have you ever taken any drugs for bone loss? No Yes If yes what medication?_____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of change in my health and medication.

_____ _____ _____
Patient (Print Name) *Patient Signature* *Date*

DR. USE ONLY: **ASA I II III IV**

DENTAL HISTORY

Name_____ Nickname_____ Age_____
Referred by_____How would you rate the condition of your mouth? ☐ Excellent ☐ Good ☐ Fair ☐ Poor
Previous Dentist _____How long have you been a patient?_____Months/Years
Date of most recent dental exam _____/_____/_____ Date of most recent x-rays _____/_____/_____
Date of most recent treatment (other than a cleaning) _____/_____/_____
I routinely see my dentist every: ☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING: **YES** **NO**

PERSONAL HISTORY

1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [____] _____ ☐ ☐
2. Have you had an unfavorable dental experience? _____ ☐ ☐
3. Have you ever had complications from past dental treatment? _____ ☐ ☐
4. Have you ever had trouble getting numb or had any reactions to local anesthetic? _____ ☐ ☐
5. Did you ever have braces, orthodontic treatment or had your bite adjusted? _____ ☐ ☐
6. Have you had any teeth removed? _____ ☐ ☐

GUM AND BONE

7. Do your gums bleed or are they painful when brushing or flossing? _____ ☐ ☐
8. Have you ever been treated for gum disease or been told you have lost bone around your teeth? _____ ☐ ☐
9. Have you ever noticed an unpleasant taste or odor in your mouth? _____ ☐ ☐
10. Is there anyone with a history of periodontal disease in your family? _____ ☐ ☐
11. Have you ever experienced gum recession? _____ ☐ ☐
12. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? _____ ☐ ☐
13. Have you experienced a burning sensation in your mouth? _____ ☐ ☐

TOOTH STRUCTURE

14. Have you had any cavities within the past 3 years? _____ ☐ ☐
15. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? _____ ☐ ☐
16. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? _____ ☐ ☐
17. Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth? _____ ☐ ☐
18. Do you have grooves or notches on your teeth near the gum line? _____ ☐ ☐
19. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? _____ ☐ ☐
20. Do you frequently get food caught between any teeth? _____ ☐ ☐

BITE AND JAW JOINT

21. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) _____ ☐ ☐
22. Do you feel like your lower jaw is being pushed back when you bite your teeth together? _____ ☐ ☐
23. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods? _____ ☐ ☐
24. Have your teeth changed in the last 5 years, become shorter, thinner or worn? _____ ☐ ☐
25. Are your teeth becoming more crooked, crowded, or overlapped? _____ ☐ ☐
26. Are your teeth developing spaces or becoming more loose? _____ ☐ ☐
27. Do you have more than one bite, squeeze, or shift your jaw to make your teeth fit together? _____ ☐ ☐
28. Do you place your tongue between your teeth or rest your teeth against your tongue? _____ ☐ ☐
29. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? _____ ☐ ☐
30. Do you clench your teeth in the daytime or make them sore? _____ ☐ ☐
31. Do you have any problems with sleep (i.e. restlessness), wake up with a headache or an awareness of your teeth? _____ ☐ ☐
32. Do you wear or have you ever worn a bite appliance? _____ ☐ ☐

SMILE CHARACTERISTICS

33. Is there anything about the appearance of your teeth that you would like to change? _____ ☐ ☐
34. Have you ever whitened (bleached) your teeth? _____ ☐ ☐
35. Have you felt uncomfortable or self conscious about the appearance of your teeth? _____ ☐ ☐
36. Have you been disappointed with the appearance of previous dental work? _____ ☐ ☐

Patient's Signature _____ Date_____
Doctor's Signature _____ Date _____

Financial Responsibility Policy

Steven P. Ellinwood, DDS. will file your dental insurance as a courtesy to you!

The contract between you as a patient and your insurance company are personal. Steven Ellinwood, DDS. is not responsible for problems between the patient and insurance carrier.

Steven P. Ellinwood, DDS. credit policy allows up to 90 days for payment by the insurance company. If no payment is received within this time period, you as the patient become personally responsible for payment and communication to your insurance carrier on the delinquent account. We will provide you with information, to the best of our abilities, in seeking reimbursement to you by your insurance carrier. It is your responsibility to pay account balances with the total of any insurance payments made to you directly by the insurance carrier.

Steven P. Ellinwood, DDS. does require that your estimated portions due are paid at the time of service.

Steven P. Ellinwood, DDS. accepts all major credit cards, cash and personal checks. In the event a personal check is returned for insufficient funds, a $25.00 fee will be applied to your account.

Steven P. Ellinwood, DDS. reserves the right to discontinue treatment for non-compliance with payment policies.

Patient Authorization

- I understand and agree to the financial responsibility policy of Steven P. Ellinwood, DDS., and hereby authorize my insurance company to pay the proceeds of any benefits due to me, directly to Steven P. Ellinwood, DDS. I also understand that my insurance carrier may send payments directly to me (or subscriber of the policy) either in error, or because of their contract outline.
- I understand and agree (regardless of my insurance status); I am responsible for any balance on my account for any professional services rendered and supplies provided. I understand further that I am responsible to ensure my bill is paid by my insurance carrier in a reasonable amount of time (within 90 days). Lack of payment, or payment made directly to me (or subscriber of the policy) will result in my prompt personal payment of my statement.
- I hereby agree to promptly pay personal balances on my account resulting from co-insurance or deductible not covered by my insurance company, at time of service.
- I understand and agree that responsibility for the payment of services, and supplies provided in this office, is mine, due and payable. Any financial arrangements that I have made are to be honored as outlined. In the event of default in payment of my account, I agree to pay such collection costs and reasonable attorney fees as may be required to effectively collect the debt.

Patient Signature: _____ **Date:** _____

Parent or Other Responsible Party: _____ **Date:** _____

Relationship to Patient: _____

Dr. Steven Ellinwood, DDS.

staff@drellinwood.com www.fortwaynecosmeticdentist.com

5725 Maplecrest Rd. Suite 1 • Fort Wayne, IN 46835--3838 (260)492-2640

Consent for Treatment by Steven P. Ellinwood, D.D.S

I, the undersigned patient, hereby authorize the undersigned provider to perform the procedure(s) or course(s) of treatment listed below. I understand my dental condition and have discussed several treatment options with the undersigned provider. I have been given a printed copy of the procedure or treatment details and any post-op instructions.

I understand the risks inherent in the treatment(s). I have discussed these risks with the dentist. The dentist has addressed all questions and concerns I have presented. I understand the expected results of the procedure(s) or course(s) of treatment. I understand that these results cannot be guaranteed and possible consequences of non-treatment.

I have disclosed my health history information, including allergies, reactions to medicine, diseases, and past procedures. I understand that withholding this information may affect the outcome of the procedure(s) or course(s) of treatment.

I authorize the undersigned provider and any other qualified assistants or medical professionals to perform the procedure(s) or treatment(s) listed below. I also give my consent for these individuals to administer any needed medicine and to perform any compulsory life-saving procedures.

I authorize any necessary life-saving procedures to be performed in the event of an emergency during the procedure(s) or course(s) of treatment. I give my consent for the administration of any medication that may be required as a life-saving measure.

I have discussed payment options and agreed upon a payment plan with the insurance company and/or the provider of service.

This Consent for Treatment is good for 1 year from this date _____ until_____.

Signature _____ **Date** _____

Response Date: _____

I, _____, have received a copy of Dr. Steven Ellinwood's Notice of Privacy Practices.

I will consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and healthcare operations. This includes transfer of any records, personal information and/or discussion with any facility we do business with regarding your dental treatment, or account status.

I have the right to read the Notice of Privacy Practices before I decide to sign the consent below. And have been given, or offered a copy of the Notice of Privacy Practices.

Dr. Ellinwood reserves the right to change the privacy practices as described in the Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

Please note that revocation of your consent must be in writing. Complaint form may be requested.

(PLEASE CIRCLE)

May we leave detailed messages on your answering machine at home? Yes
If NO, we will leave a brief confirmation/reminder, or request to call on your machine.

May we call you at work? Yes

May we leave a detailed message on your Voice Mail at work? Yes
If NO, may we leave a brief confirmation/reminder on your Voice Mail? Yes

May we leave a message with a secretary or coworker? Yes

May we contact you by email? Yes

If YES, Email Address to use _____

May we discuss your care and/or account with others in your household? Yes

If so, please tell us who: (names)_____

_____

Signature_____Date_____

(Signature of Parent or Guardian if Minor Child)