WELCOME

PATIENT INFORMATION DATE_____

CHILD'S LAST NAME_____FIRST_____MIDDLE_____

ADDRESS_____CITY_____STATE_____ZIP_____
_

PHONE_____BIRTHDATE_____MALE____FEMALE____SCHOOL_____

HOW DID YOU HEAR ABOUT OUR OFFICE?_____

RESPONSIBLE PARTY INFORMATION

FATHER'S NAME_____MARITAL STATUS_____

MAILING ADDRESS_____CITY_____STATE_____ZIP_____

HOME PHONE_____WORK PHONE_____

SOCIAL SECURITY #_____BIRTHDATE_____

EMPLOYER_____OCCUPATION_____

MOTHER'S NAME_____MARITAL STATUS_____

MAILING ADDRESS_____CITY_____STATE_____ZIP_____

HOME PHONE_____WORK PHONE_____

SOCIAL SECURITY **#**_____BIRTHDATE_____

EMPLOYER_____OCCUPATION_____

WHO IS FINANCIALLY RESPONSIBLE FOR THE CHILD?_____

EMERGENCY CONTACT_____RELATIONSHIP_____

ADDRESS_____PHONE #_____

PLEASE COMPLETE OTHER SIDE

MINOR CHILD TREATMENT RELEASE

I GIVE MY PERMISSION TO DR. STEVEN P. ELLINWOOD AND/OR HIS DESIGNATED ASSISTANT TO PERFORM ANY AND ALL DENTAL TECHNIQUES AND PROCEDURES, INCLUDING BUT NOT LIMITED TO THE ADMINISTRATION OF NITROUS OXIDE SEDATION AND ANESTHETICS, ON MY CHILD _____, WHETHER OR NOT I AM PRESENT AT THE ACTUAL APPOINTMENT WHEN THE TREATMENT IS RENDERED. I FURTHER EXPRESSLY AGREE TO BE FINANCIALLY RESPONSIBLE FOR ALL TREATMENT RENDERED TO THE ABOVE-NAMED CHILD AS OUTLINED IN THE FINANCIAL POLICY AGREEMENT.

SIGNED_____DATE_____

RELATIONSHIP TO CHILD_____

DENTAL INSURANCE INFORMATION

INSURED'S NAME_____INSURED'S SOC. SEC. #_____

PRIMARY INSURANCE COMPANY_____GROUP #_____

INSURANCE CO. ADDRESS_____

SECONDARY INSURANCE CO._____GROUP #_____

SECONDARY INSURANCE CO. ADDRESS_____

SUBSCRIBER'S NAME_____BIRTHDATE_____

INSURED'S SOC. SEC. #_____RELATIONSHIP TO PATIENT_____

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 THE UNDERSIGNED HAD PERSONALLY SIGNED THE PARTICULAR CLAIM.

I, _____(NAME OF INSURED), HEREBY AUTHORIZE
MY PRESENT INSURANCE COMPANY TO PAY AND HEREBY ASSIGN DIRECTLY TO DR. STEVEN P. ELLINWOOD ALL DENTAL BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR SERVICES AS DESCRIBED ON THE ATTACHED FORMS.
AUTHORIZATION IS HEREBY GIVEN TO RELEASE ALL INFORMATION NECESSARY TO THE PAYMENT OF SAID BENEFITS.

AUTHORIZED SIGNATURE_____DATE_____

CHILD'S HEALTH HISTORY

DENTAL HISTORY

CHILD'S NAME_____**DATE**_____

DATE OF LAST VISIT TO A DENTIST_____**SERVICES?**_____

YES NO HAS CHILD COMPLAINED ABOUT DENTAL PROBLEMS?_____

YES NO ANY UNHAPPY DENTAL EXPERIENCES?_____

YES NO ANY INJURIES TO MOUTH/TEETH/HEAD?_____

YES NO ANY MOUTH HABITS (THUMBSUCKING, PACIFIER, ETC.)?_____

YES NO ANY UNUSUAL SPEECH HABITS?_____

YES NO ANY LOST TEETH?_____

YES NO HAVE MISSING TEETH BEEN REPLACED?_____

YES NO ORTHODONTIC APPLIANCES WORN NOW OR EVER BEEN?_____

YES NO DOES YOUR CHILD BRUSH TEETH DAILY?_____

YES NO DO YOU ASSIST CHILD WITH TOOTH BRUSHING?_____

YES NO HOW OFTEN?_____

YES NO IS DENTAL FLOSS USED?_____**HOW OFTEN?**_____

YES NO ARE DISCLOSING TABLETS USED?_____

YES NO IS FLUORIDE TAKEN IN ANY FORM?_____

YES NO DO YOU DESIRE COMPLETE DENTAL SERVICE FOR THE CHILD?_____

CHILD'S ATTITUDE TO DENTISTRY?_____

DOCTOR'S NOTES:

_____

_____

_____

_____

_____

_____

_____

PLEASE COMPLETE OTHER SIDE

CHILD'S MEDICAL HISTORY

CHILD'S PHYSICIAN_____**ADDRESS**_____

PHONE_____**DATE OF LAST PHYSICAL EXAM**_____

RESULTS_____

YES NO IS CHILD UNDER CARE OF PHYSICIAN NOW?_____

YES NO IS CHILD RECEIVING ANY MEDICATION OR DRUGS?_____

YES NO HAS CHILD EVER BEEN HOSPITALIZED?_____**WHEN?**_____

YES NO HAS CHILD EVER HAD SURGERY?_____

YES NO DOES CHILD HAVE GOOD PHYSICAL COORDINATION?_____

YES NO ARE THERE ANY EMOTIONAL PROBLEMS?_____

YES NO ARE THERE ANY ALLERGIES TO MEDICATIONS? _____

YES NO ARE THERE OTHER ALLERGIES: FOOD, POLLEN, ANIMALS, DUST, OTHER?_____
_____

HAS CHILD ANY HISTORY OF OR DIFFICULTY WITH ANY OF THE FOLLOWING?:

N	ANEMIA	N	BLADDER	N	EPILEPSY	N	LIVER	N	RHEUMATIC FEVER
N	ACQUIRED IMMUNE DEFICIENCY SYNDROME	N	CEREBRAL PALSY	N	FAINTING	N	MALIGNANCIES	N	THYROID
N	ASTHMA	N	CHICKEN POX	N	HEARING	N	MASTOID	N	TUBERCULOSIS
N	AIDS RELATED COMPLEX	N	CHRONIC SINUS	N	HEART	N	MEASLES	N	VENEREAL DISEASE
		N	CONVULSIONS	N	HIV	N	MONONUCLEOSIS	N	OTHER
		N	DIABETES	N	KIDNEY	N	MUMPS		

SUMMARY: (FOR DOCTOR'S USE)_____

_____

_____

PLEASE DESCRIBE ANY CURRENT MEDICAL TREATMENT INCLUDING DRUGS, PENDING SURGERY, RECENT INJURIES, OR ANY OTHER INFORMATION I SHOULD BE AWARE OF THAT WE HAVE NOT DISCUSSED.

_____

_____

MAY WE REQUEST RELEASE OF YOUR CHILD'S MEDICAL RECORDS FOR OUR REFERENCE?_____

THIS INFORMATION WAS DISCUSSED WITH AND GIVEN BY_____**RELATIONSHIP**_____

I CERTIFY THE ABOVE TO BE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

PARENT/GUARDIAN 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

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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)