

# WELCOME

Please take a few minutes to complete the following confidential information. If you have any questions we'll be glad to help you.

## **Patient Information**

Date _____	Social Security # _____	Birth Date _____	
Last Name _____	First Name _____	Home Phone _____	
Address _____			
City _____	State _____	Zip Code _____	
<input type="checkbox"/> Male	<input type="checkbox"/> Female	Age _____	
<input type="checkbox"/> Single	<input type="checkbox"/> Married	<input type="checkbox"/> Divorced	<input type="checkbox"/> Widowed
E-Mail address _____		Cell Phone _____	
Where can you be reached during the day? <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell <input type="checkbox"/> E-Mail			
Patient Employed by _____		Occupation _____	
Business Address _____		Business Phone _____	
Whom may we thank for referring you? _____			
Person to Contact in case of an emergency _____		Phone _____	
Closest relative not living with you _____		Phone _____	
Address _____			

## **Primary Dental Insurance**

Employee (Subscriber) _____		
Insurance Company _____	Group # _____	
Employer _____		
Business Address _____	Phone _____	
Occupation _____		
Employee date of Birth _____	Social Security # _____	Date _____

## **Secondary Dental Insurance**

Employee (Subscriber) _____		
Insurance Company _____	Group # _____	
Employer _____		
Business Address _____	Phone _____	
Occupation _____		
Employee date of birth _____	Social Security # _____	Date employed _____

## **Assignment and Release**

I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

Date \_\_\_\_\_ Signature \_\_\_\_\_

Ellington Family Dentistry, Ellington and Hulbert D.D.S. P.C.

# ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

\*You May Refuse to Sign This Acknowledgement

I, \_\_\_\_\_ have received a copy of the office's Notice of Privacy Practices.

\_\_\_\_\_  
Please Print Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining the acknowledgement
- Other (please specify)

## CONSENT FOR TREATMENT

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of (name of patient) \_\_\_\_\_'s dental needs.
2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
3. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.
4. I have completed this form fully and completely, and certify that I am the patient or responsible party of the patient authorized to furnish the information requested. I understand that even though I have some type of insurance, I am financially responsible to the dentist for the charges incurred by myself and/or my dependents. I agree that in the event my account is past due for ninety days from the date of service, and is turned over to the attorney for collection, I will be liable for attorney's fees, plus all court costs. I will pay interest on accounts past due 30 days or more at the rate of 1.5% per month (18% annually).
5. I understand that in the event that I cancel an appointment within 24 hours of the appointed time I will be charged a cancellation fee.

Patient \_\_\_\_\_ Date \_\_\_\_\_ Witness \_\_\_\_\_

Parent or Responsible Party \_\_\_\_\_ Relationship to Patient \_\_\_\_\_