

NEW PATIENT INFORMATION FORM

Mark if new: Address  / Insurance

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Patient: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Birthdate: \_\_\_/\_\_\_/\_\_\_ Social Security # \_\_\_\_\_

Male  Female

Employer: \_\_\_\_\_

Occupation: \_\_\_\_\_

REFERRED TO THIS OFFICE BY: \_\_\_\_\_

Home: \_\_\_\_\_ Work: \_\_\_\_\_

Cell: \_\_\_\_\_ Best time to call: \_\_\_\_\_

Email: \_\_\_\_\_

Single  Married

Spouse's Name: \_\_\_\_\_

Spouse's Employer: \_\_\_\_\_

Spouse's Occupation: \_\_\_\_\_

DENTAL INSURANCE

Provider Name : \_\_\_\_\_

Subscriber's Name \_\_\_\_\_

Birthdate: \_\_\_/\_\_\_/\_\_\_ Social Security # \_\_\_\_\_

Employer: \_\_\_\_\_

Group #: \_\_\_\_\_

If you have additional dental coverage:

Provider Name : \_\_\_\_\_

Subscriber's Name \_\_\_\_\_

Birthdate: \_\_\_/\_\_\_/\_\_\_ Social Security # \_\_\_\_\_

Employer: \_\_\_\_\_

Group #: \_\_\_\_\_

Person responsible for the account: \_\_\_\_\_

DENTAL HISTORY

Do you have or do you use any of the following – indicate with (x):

- Checkboxes for dental history items: Sensitive to cold, heat, sweets or pressure; Bad breath; Tobacco Use - Cigarette, cigar, chewing; Bleeding gums. How long?; Unpleasant taste; Take more than one alcoholic drink per day; Food impaction; Unfavorable dental experience; Fluoride supplements, rinses; Clenching or grinding; Complications from extractions; TMJ treatment (jaw joint); Burning of tongue; Periodontal treatment; Fingernail biting, cheek biting, etc; Swelling or lumps in mouth; Orthodontic treatment; Consent for Nitrous Oxide sedation; Frequent sores on lips or mouth; Mouth breathing; Pain around ear or jaw

How do you feel about your smile?

- Would you like your teeth whiter? Yes  No  Do you think your teeth are too crooked? Yes  No  Are you concerned with stains on your teeth? Yes  No  Do you have missing teeth that you would like replaced? Yes  No

I would like more information about: \_\_\_\_\_

CONSENT

- 1. The undersigned hereby authorizes the doctor to take x-rays, study models, photographs, or any diagnostic aid deemed appropriate by the doctor to make a thorough diagnosis of the patient's dental needs.
2. I also authorize the doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment in connection with (name of patient) I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that the doctor choose and employ such assistance as deemed fit to provide recommended treatment.
3. I understand that where appropriate permission is given for the doctor and staff to send necessary models, x-ray and health related information to appropriate dental specialists or insurance carriers. This permission will remain in force as long as I am a patient of this dental practice. I also authorize release of photographs or other images for educational publication or presentation.
4. I understand that all responsibility for payment for dental service provided in this office for myself or my dependents is mine, due and payable at the time of services are rendered, unless other arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that a 1.5% finance charge (18% APR) may be added to my account in addition to any collection charges.
5. I understand that where appropriate, credit bureau reports may be obtained.
6. I understand that it is my responsibility to advise your office of any changes in the information contained on this form.

Patient: \_\_\_\_\_

Date: \_\_\_\_\_ Witness: \_\_\_\_\_

Parent or Responsible Party: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Emergency Contact Person: \_\_\_\_\_

Phone: \_\_\_\_\_

FOR OFFICE USE:

Reviewed by Dr \_\_\_\_\_

Date: \_\_\_\_\_