Dental Group of Ellisville, PLLC
97 Hal Crocker Road
Ellisville, MS 39437

(601) 477-3779

Thank you for trusting us with your dental care. We promise to do our best to provide you with the finest care available. If you have any questions please do not hesitate to call us.

Patient # _____

Date _____

PATIENT INFORMATION

Name _____ Birthdate _____ SS# _____

Address _____ City _____ State _____ Zip _____

Sex ☐M ☐F ☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Home Phone # ( ) _____ Cell Phone #1 ( ) _____ Email _____

Employer _____ Employer Phone ( ) _____

Employer Address _____ City _____ State _____ Zip _____

Spouse or Parent's Name _____ Employer _____ Work Phone ( ) _____

Whom may we thank for referring you? _____

Person to contact in case of emergency _____ Phone ( ) _____

RESPONSIBLE PARTY

Name of Person
Responsible for this Account _____ Relation to Patient _____

Address _____ Home Phone ( ) _____

Birthdate _____ Currently a patient in our office? ☐Yes ☐No

Employer _____ Work Phone ( ) _____

E-Mail _____ Cell Phone ( ) _____

DENTAL INSURANCE INFORMATION

Name of Insured _____ Relation to Patient _____

Birthdate _____ Social Security # _____ Date Employed _____

Employer _____ Work Phone # ( ) _____

Employer Address _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Union or Local # _____

Address _____ City _____ State _____ Zip _____

How much is your deductible? _____ How much have you used? _____ Max. Annual Benefit _____

ADDITIONAL DENTAL INSURANCE

Name of Insured _____ Relation to Patient _____

Birthdate _____ Social Security # _____ Date Employed _____

Employer _____ Work Phone # ( ) _____

Employer Address _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Union or Local # _____

Address _____ City _____ State _____ Zip _____

How much is your deductible? _____ How much have you used? _____ Max. Annual Benefit _____

DENTAL HISTORY

Reason for today's visit _____ Date of last dental care _____

Former Dentist _____ Date of last dental X-rays _____

Address _____

Check (✓) if you have or have had problems with any of the following:

☐ Bad Breath	☐ Grinding Teeth	☐ Sensitivity to hot
☐ Bleeding Gums	☐ Loose teeth or broken fillings	☐ Sensitivity to sweets
☐ Clicking or popping jaw	☐ Periodontal treatment	☐ Sensitivity when biting
☐ Food collecting between the teeth	☐ Sensitivity to cold	☐ Sores or growths in your mouth

How often do you floss? _____ How often do you brush? _____

MEDICAL HISTORY

Physician's Name _____ Date of last visit _____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pndimin (fenfluramine) and Redux (dexfenfluramine). ☐Yes ☐No

Have you ever had any serious illnesses or operations?? ☐Yes ☐No If yes, describe _____

Have you ever had a blood transfusion? ☐Yes ☐No If yes, give approximate dates _____

(Women) Are you pregnant? ☐Yes ☐No Nursing? ☐Yes ☐No Taking birth control pills? ☐Yes ☐No

Check (✓) if you have or have had problems with any of the following:

☐ Anemia	☐ Congenital Heart lesions	☐ Hepititis	☐ Scarlet Fever
☐ Arthritis, Rheumatism	☐ Cortisone Treatments	☐ Hernia Repair	☐ Shortness of Breath
☐ Artificial Heart Valves	☐ Cough, Persistent	☐ High Blood Pressure	☐ Skin Rash
☐ Artificial Joints, Pins, etc.	☐ Cough up Blood	☐ HIV/AIDS	☐ Stroke
☐ Asthma	☐ Diabetes	☐ Jaw Pain	☐ Swelling of Feet or Ankles
☐ Back Problems	☐ Epilepsy	☐ Kidney Disease	☐ Thyroid Problems
☐ Bleeding Abnormally	☐ Fainting	☐ Liver Disease	☐ Tobacco Habit
☐ Blood Disease	☐ Glaucoma	☐ Mitral Valve Prolapse	☐ Tonsillitis
☐ Cancer	☐ Headaches	☐ Pacemaker	☐ Tuberculosis
☐ Chemical Dependency	☐ Heart Murmur	☐ Radiation Treatment	☐ Ulcer
☐ Chemotherapy	☐ Heart Problems	☐ Respiratory Disease	☐ Venereal Disease
☐ Circulatory Problems	☐ Hemophilia	☐ Rheumatic fever	

List medications you are currently taking:

_____ _____

_____ _____

_____ _____

Allergies:

☐ Aspirin	☐ Local Anesthetic	☐ Iodine	☐ Other _____
☐ Barbiturates (Sleeping Pills)	☐ Penicillin	☐ Latex	_____
☐ Codeine	☐ Sulfa	☐ None	

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my mindor child, ever have a change in health.

_____ _____

Signature of of Patient, Parent, Guardian or Personal Representative Date

_____ _____

Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

Payment is due in full at time of treatment unless prior arrangements have been approved.

Financial Policy:

Thank you for choosing Dental Group of Ellisville as your health care provider. We are committed to your treatment being successful. Please understand that payment of our bill is considered part of your treatment. The following is a statement of our financial policy/consent form, which we require you to read and sign prior to any treatment. All patients must complete our information form before seeing the doctor. We expect full payment at the time of service. We will accept cash, checks, MasterCard, Visa and Care Credit.

Regarding Insurance:

We may accept assignment of insurance benefits after your visit. However, we do require your percentage of the bill to be paid at the time of service. **The balance is your responsibility whether your insurance pays or not.** We cannot bill your insurance company unless you give us your insurance information. Your insurance policy is a contract between you and your insurance company. We are not a party to the contract. In the event we do accept assignment of benefits we require that you be prepared to pay the balance of the account that is not covered by your insurance company. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under your dental insurance.

Usual and Customary Rates:

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. Any account we do not receive payment on within 90 days will go to collections, NO EXCEPTIONS!!
_____ initial here.

Adult Patients:

Adult patients are responsible for payment at the time of service.

Minor Patients:

There must be an adult accompanying a minor and the parents (or guardians) are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless prior arrangements have been made to make payment.

Terms and Agreements:

I assume full responsibility for the bill incurred. I understand that payment is due at the time services are rendered. I further understand that in the event of a returned check, a $30.00 fee will be assessed. I also understand and agree if this account goes into default I will be responsible for all court costs, attorneys' fees, and collection fees which will total to 35% of the balance of the account at the time of default. I understand that dentistry is not an exact science and success cannot be guaranteed. I also understand the results of my examination, the proposed treatment, possible complications, and the anticipated results. This includes the administration of local anesthetic/sedation methods (such as laughing gas) may be needed. I also authorize the administration of radiographs as an important and necessary diagnostic tool. I authorize Dental Group of Ellisville and/or associates and assistants as may be necessary to perform the needed procedures.

***As of February 1, 2011 all accounts over 30 days past due will be subject to a $3.00 billing charge per statement.**

I have read the financial policy/consent form. I understand and agree to the terms above.

_____ _____

Signature of Patient or responsible party **Date**