

We Want to Take Care of Your Concerns and Needs First....

What are you present dental problems? _____
_____.

Do you avoid brushing any part of your mouth? Yes No

Do your gums bleed when brushing? Yes No

Are your teeth sensitive to sweet, hot/cold or biting pressure? Yes No

I want to know about longer lasting solutions that may cost more. Yes No

Are you dissatisfied with your teeth and their appearance? Yes No

Does dental treatment make you nervous?

No Slightly Moderately Very

I think my dental health is...

Excellent Good Fair Poor

If I could change my smile I would make my teeth...

Whiter Straighter Close Spaces Repair Chips

Any other concerns/needs of mine are: _____

_____.

When was the last time you saw the dentist?

_____.



PATIENT REGISTRATION

First Name: _____ Last Name: _____ Middle Initial: _____

Preferred Name: _____

Responsible Party (if someone other than the patient)

First Name: _____ Last Name: _____ Middle Initial: _____

Address: _____

City, State, Zip: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Birth Date: _____ Soc Sec: _____ Drivers Lic: _____

Patient Information

Address: _____

City: _____ State / Zip: _____

Home Phone : _____ Work Phone: _____ Cellular: _____

Sex: Male Female Marital Status: Married Single Divorced Separated

Birth Date: _____ Age: _____ Soc. Sec: _____ Drivers Lic: _____

E-Mail: _____ I would like to receive correspondences via e-mail.

Section 2 Employment

Employer: _____ Position: _____

Employment Status: Full Time Part Time Retired

Student Status: Full Time Part Time

Section 3 Misc.

Referred By: _____

Previous Dentist: _____

Emergency Contact: _____

Pharmacy: _____

Primary Insurance Information

Name of Insured: _____ Relationship to Insured: Self Spouse Child

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____

Ins. Company: _____

Address: _____

Address: _____

City, State, Zip: _____

City, State, Zip: _____

Santa Rosa Dental Care

Medical History

PATIENT NAME _____ BIRTH DATE _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? **Yes No** If yes please explain: _____

Have you ever been hospitalized or had a major operation? **Yes No** If yes please explain: _____

Have you ever had a serious head or neck injury? **Yes No** If yes please explain: _____

Are you taking any medications, pills, or drugs? **Yes No** If yes please explain: _____

Are you on a special diet? **Yes No** _____

Do you use tobacco? **Yes No** _____

Do you use controlled substances? **Yes No** _____

Women: Are you...

Pregnant/Trying to get pregnant? **Yes No** Taking oral contraceptives? **Yes No** Nursing? **Yes No**

Are you allergic to any of the following (please circle the ones that apply to you)...

Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics

Other If yes, please explain: _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive	Yes No	Cortisone Medicine	Yes No	Hemophilia	Yes No	Renal Dialysis	Yes No
Alzheimer's Disease	Yes No	Diabetes	Yes No	Hepatitis A	Yes No	Rheumatic Fever	Yes No
Anaphylaxis	Yes No	Drug Addiction	Yes No	Hepatitis B or C	Yes No	Rheumatism	Yes No
Anemia	Yes No	Easily Winded	Yes No	Herpes	Yes No	Scarlet Fever	Yes No
Angina	Yes No	Emphysema	Yes No	High Blood Pressure	Yes No	Shingles	Yes No
Arthritis/Gout	Yes No	Epilepsy or Seizures	Yes No	Hives or Rash	Yes No	Sickle Cell Disease	Yes No
Artificial Heart Valve	Yes No	Excessive Bleeding	Yes No	Hypoglycemia	Yes No	Sinus Trouble	Yes No
Artificial Joint	Yes No	Excessive thirst	Yes No	Irregular Heartbeat	Yes No	Spina Bifida	Yes No
Asthma	Yes No	Fainting Spells/Dizziness	Yes No	Kidney Problems	Yes No	Stomach/Intestinal Disease	Yes No
Blood Disease	Yes No	Frequent Cough	Yes No	Leukemia	Yes No	Stroke	Yes No
Blood Transfusion	Yes No	Frequent Diarrhea	Yes No	Liver Disease	Yes No	Swelling of Limbs	Yes No
Breathing Problem	Yes No	Frequent headaches	Yes No	Low Blood Pressure	Yes No	Thyroid Disease	Yes No
Bruise Easily	Yes No	Genital Herpes	Yes No	Lung Disease	Yes No	Tonsillitis	Yes No
Cancer	Yes No	Glaucoma	Yes No	Mitral Valve Prolapse	Yes No	Tuberculosis	Yes No
Chemotherapy	Yes No	Hay Fever	Yes No	Pain in Jaw Joints	Yes No	Tumors or Growths	Yes No
Chest Pains	Yes No	Heart Attack/Failure	Yes No	Parathyroid Disease	Yes No	Ulcers	Yes No
Cold Sores/Fever Blisters	Yes No	Heart Murmur	Yes No	Psychiatric Care	Yes No	Venereal Disease	Yes No
Congenital Heart Disorder	Yes No	Heart Pace Maker	Yes No	Radiation Treatments	Yes No	Yellow Jaundice	Yes No
Convulsions	Yes No	Heart Trouble/Disease	Yes No	Recent Weight Loss	Yes No		

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patients) health. It is my responsibility to inform the dental office of any changes in medical status. I agree that regardless of insurance coverage, I am responsible for payment of services rendered and that any part of my account balance ages past 30 days, a finance charge of 1.5% monthly will be applied.

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN _____ DATE _____

Jeffrey Elliott, DDS

301 College Ave | Santa Rosa CA, 95401 | 707-546-0429

Financial Policy

Thank you for choosing Jeffrey Elliott, DDS. Our primary mission is to deliver the best and most comprehensive dental care available. Our fees are based on the quality of the materials we use and our experience in performing your needed treatment. We strive to maximize your insurance benefits and make any remaining balance easily affordable. To facilitate our mission we offer the following payment options.

Payment Options:

You can choose from:

- Cash or Check are always welcome.
- Visa, Mastercard, and American Express are accepted in our office.
- We also offer NO INTEREST¹ Payment Plans² from CareCredit and Chase Health Advance
 - o Allow you to pay over time with NO INTEREST¹
 - o Convenient, low monthly payment plans² also available
 - o No annual fees or pre-payment penalties

Please note:

Jeffrey Elliott, DDS requires payment at time of treatment. If you choose to discontinue care before treatment is complete, you will receive a refund less the cost of care received.

For patients with dental insurance we are happy to work with your carrier to maximize your benefit, and, as a courtesy, we will bill your dental insurance carrier. The patient is responsible for insurance claims not paid within 30 days of service.

Balances over 30 days are subject to a 1½% per month (18%) per annum finance charge.

A fee of \$50 is charged for patients who miss or cancel more than one time in a calendar year without 48-hour notice.

Jeffrey Elliott, DDS charges \$25 for returned checks.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

Patient, Parent or Guardian Signature

Date

Patient Name (Please Print)

¹If paid within the promotional period. Otherwise, interest assessed from purchase date. Minimum monthly payment required.

²Subject to credit approval

Jeffrey C. Elliott, D.D.S.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, _____, have received a copy of this 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 acknowledgement
- Other (Please Specify)