Drs. Ellis, Green and Jenkins

WELCOME TO OUR PRACTICE

Patient Information

Today's Date: _____

First Name: _____ MI: _____ Last Name: _____

Birthdate: _____ Age: _____ SS#: _____ Marital Status: ☐ Married ☐ Single ☐Widowed ☐Divorced ☐ Separated

Address: _____ Email: _____

Home #: _____ Cell #: _____ Occupation: _____ Employer: _____

Work #: _____ Emergency Contact Name: _____ E.C. Phone #: _____

Referral Information

Who may we thank for referring you to our practice? _____

If you have children that are patients at our practice, please list their names: _____

Responsible Party

First Name: _____ MI: _____ Last Name: _____

Birthdate: _____ Age: _____ SS#: _____ Occupation: _____ Employer: _____

Employer's Address: _____ Employer's Work #: _____

Insurance Information

Primary Dental Insurance

Insurance Co. Name: _____ Insurance Co. Address: _____

Insurance Co. Phone #: _____ Policy #: _____ Group #: _____ Plan #: _____

Subscriber's Name: _____ Relationship to Patient: _____ Subscriber's DOB: _____

Subscriber's Social Security #: _____ Subscriber's Employer: _____

Secondary Dental Insurance

Insurance Co. Name: _____ Insurance Co. Address: _____

Insurance Co. Phone #: _____ Policy #: _____ Group#: _____ Plan #: _____

Subscriber's Name: _____ Relationship to Patient: _____ Subscriber's DOB: _____

Subscriber's Social Security #: _____ Subscriber's Employer: _____

Dental History

Reason for today's visit: _____ Previous Dentist: _____ Date of last visit: _____

What was done at last visit? _____ Last Cleaning: _____ How often do you brush: _____

Gums bleed: ☐ Yes ☐ No Experiencing any of the following? ☐ Sensitive teeth ☐ Loose teeth ☐ Broken fillings ☐ Jaw Pain ☐ Injuries to teeth

If you checked any of the boxes above, please explain: _____

Unpleasant Dental Experience: ☐ Yes ☐ No Explain: _____

Have you ever had? ☐ Orthodontics ☐ Veneers ☐ Gum Treatment ☐ Implants ☐ Root Canal ☐ Crowns ☐ Oral Surgery

Are you happy with the appearance of your teeth? ☐ Yes ☐ No *(check all that apply)* ☐ Color ☐ Position ☐ Smile Have you ever had tooth whitening? ☐ Yes ☐ No

Are you interested in replacing any missing teeth? ☐ Yes ☐ No - Which Method ☐ Dentures ☐ Bridges ☐ Implants

Do you have any questions for the doctor? ☐ Yes ☐ No

Medical History

Physician's Name: _____ Office Address: _____ Office Phone #: _____

Are you currently under the care of a physician? ☐ Yes ☐ No - Explain: _____

Has there been a recent change in your health? ☐ Yes ☐ No - Explain: _____

Are you currently taking any prescription, over the counter, or recreational drugs? ☐ Yes ☐ No - Explain: _____

_____

Have you been hospitalized or had a serious illness within the past five years? ☐ Yes ☐ No - Explain: _____

Have you been treated now or in the past with Bisphosphonates for Osteoporosis or cancer? ☐ Yes ☐ No - Explain: _____

_____

Are you pregnant or is it likely that you could be pregnant at this time? ☐ Yes ☐ No - Explain: _____

Do you? ☐ Take Diet Pills ☐ Wear Contact Lenses ☐ Take Herbal Supplements ☐ Chew Tobacco – Years? _____ Can(s) per day? _____

☐ Smoke – Years? _____ Pack(s) per day? _____ ☐ Drink Alcohol - Per week? _____ Per month? _____

Circle if you have or ever had

Y N Artificial Limb/Joint/Hip	Y N High/Low Blood Pressure	Y N Organ Transplant	Y N Sinus Problems
Y N Migraines	Y N Frequent Headaches	Y N Claustrophobia	Y N Artificial Heart Valve
Y N Prolonged Bleeding	Y N Ulcers/Colitis	Y N Hay Fever	Y N Head Injury
Y N Venereal Disease	Y N Mitral Valve Prolapse	Y N Acid Reflux	Y N Arthritis
Y N Epilepsy/Seizures	Y N STD	Y N Rheumatic Fever	Y N Radiation Therapy
Y N Stomach Problems	Y N Glaucoma	Y N Dizziness/Fainting Spells	Y N Treated for AIDS, HIV
Y N Heart Murmur	Y N Thyroid Problems	Y N Used Diet Drug Fen-Phen	Y N Anemia
Y N Chronic Diarrhea	Y N Stroke TIA	Y N Joint Surgery	Y N Cancer/Chemotherapy
Y N Blood Disorder	Y N Increased Frequent Urination	Y N Bells Palsy	Y N Heart Disease
Y N Diabetes	Y N Asthma	Y N Night Sweats	Y N Shingles
N Recurrent Infections	Y N Angina	Y N Kidney Problems	Y N Bronchitis
Y N Addictions	Y N Pace Maker	Y N Liver Problems	Y N Emphysema
Y N TMJ Problems	Y N Shortness of Breath	Y N Hepatitis: A or B or C	Y N Tuberculosis
Y N Unexplained Weight Loss	Y N Mouth Ulcers	Y N Aspirin Daily	

Please mark any allergies/adverse reactions:

Y N Penicillin	Y N Tetracycline	Y N Erythromycin	Y N Sulfa
Y N Local Anesthetics	Y N Codeine	Y N NSAID (Advil/Mortrin)	Y N Gluten
Y N Aspirin	Y N Valium	Y N Barbiturates	Y N Latex
Y N Iodine	Y N Household Bleach		

Any medical history not listed above? Please explain: _____

Authorization

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of changes in my medical status. I authorize the dental staff to perform the necessary dental services I may need. It is also my responsibility to inform this office of any changes in my insurance coverage. I understand that payment is due at the time services are rendered.

_____ _____

Patient or Responsible Party's Signature Date

_____

Please Print Patient's or Responsible Party's Name

Drs. Ellis, Green and Jenkins

Financial Agreement and Office Policies

The dentists and staff of Drs. Ellis, Green and Jenkins are dedicated to providing you and/or your child/ren with the best possible care and service. Understanding our financial agreement is an important part of your care and treatment.

- Your **estimated** patient responsibility (co-insurance and deductible) is due in full at the time of service.
- We accept cash, checks, money orders, Visa, MasterCard, and Discover and Care Credit.
- Visa, MasterCard, and Discover payments can be processed over the phone.
- Payments may also be made through our website via PayPal.

Insurance:

By providing your insurance information, you have agreed to be responsible for services provided. It is very important that you know the terms of your plan, including benefits, limitations, co-insurance, deductible, remaining max and out of pocket expense before each scheduled appointment.

- While many insurance companies are only allowing bitewings once a year, our doctors may recommend taking x-rays more frequently. Bitewing x-rays and fluoride treatment may be performed at each routine cleaning for patients 4 years and older, unless the patient, parent or guardian informs the assistant at the beginning of their visit that they do not wish to have bitewings taken and/or have fluoride applied.
    - The bitewing x-rays allow the doctor to see any decay that may be in-between the patient's teeth, which the dentist otherwise would not be able to see.
    - Fluoride application is also recommended every six months, as it helps strengthen the enamel of your teeth and it helps prevent decay.

We will file **all** of your dental claims regardless of your insurance plan and are in-network providers with United Concordia, BCBS Grid Network, BCBS State Dental Plus, MetLife and Delta Dental Premier. If there is secondary coverage, that information must be provided before the scheduled appointment. If provided after the appointment, you will be responsible for filing the claim to your secondary insurance carrier.

We will collect your portion due (co-insurance) and deductible as estimated based on our system at the time services are rendered. Any pre-estimate or treatment plan provided to you is **not** a guarantee of payment. Payment is determined by your insurance company upon receipt of a claim. Payment is due in **full** at the time services are rendered **if** the patient is under a pre-existing clause or has reached the annual maximum.

For our self-pay patients, payment is due in full at the time of service.

Past Due Accounts:

If your account becomes past due, we will take necessary steps to collect the balance owed. If we have to refer your account to a collection agency, you are required to pay all of the collection costs which are incurred.

Separation / Divorce:

In the situation of a divorce or separation, the parent authorizing treatment for a child will be the parent responsible for their treatment fees. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent. As always, the person bringing the child to the appointment will be expected to pay as required.

Returned Checks:

In the rare case of a returned check for insufficient funds, we will electronically debit your account for the amount of the check plus a processing fee of $30.00. Unpaid returned checks will be forwarded to the Richland County Solicitor's Office.

Confirming of Appointments:

We will make every attempt to contact you to remind you of yours and/or your child's appointment. However, your confirmation reminder is a courtesy to you; we encourage you to record the scheduled information on your calendar.

Missed / Canceled Appointments:

The second time a patient misses an appointment, or cancels with less than 24 hours notice from the appointment time; we may assess a fee. This fee must be paid before a new appointment is scheduled. Patients with multiple missed appointments will be asked to transfer their records to another office. Exceptions will be considered on an individual basis.

THE OFFICE POLICIES CONTINUE ON THE NEXT PAGE.

CONTINUATION OF OFFICE POLICIES

Missed / Canceled Appointments for patients with South Carolina Healthy Connections Coverage:
The second time a patient misses an appointment, or cancels with less than 24 hours notice from the appointment time; we may notify your insurance company of the missed appointment. Patients with multiple missed appointments will be asked to transfer their records to another office. Exceptions will be considered on an individual basis.

Scheduling:
We try, whenever possible, to accommodate your need for appointment times that fit your schedule. There are certain types of procedures and ages of children, however that we schedule at specific times in order to provide the best care possible.

For additional information, please visit our website: www.wecaredentalsc.com.

Thank you for reviewing our Financial Agreement and Office Policies. Please read the following, initial each section and sign and date the bottom of this form.

_____ Full payment is due at the time of service unless arrangements have been made prior to the start of any treatment.

_____ Insurance balances are ultimately the patient's obligation. We will file most primary insurances at no cost to you as a courtesy. However, insurance balances which are not paid within 60 days may be billed to you. Please keep your walk-out statements and follow up with your insurance carrier to ensure prompt payment.

_____ Some of your treatment may not be covered by your insurance carrier. The cost for such charges will be your responsibility.

_____ Major services may require a deposit equal to at least one half of the estimated patient portion at the time the appointment is made.

_____ Patients are asked to confirm their appointments at least 48 hours in advance by directly contacting our office or by responding to our confirmation contact. Failure to confirm your appointment may result in a charge for the time reserved.

I have read and understand the financial agreement of Drs. Ellis, Green and Jenkins and I agree to comply with its terms. I understand that I am financially responsible for all charges whether or not they are covered by insurance and agree such terms may be amended from time-to-time by the practice.

_____ Print Your Name (Responsible Party)

_____ Print Patient's Name

_____ Signature (Responsible Party)

_____ Date

Patient Consent to Receive Mail, E-mail, and/or Telephone Messages

Please Print (Last Name) (First Name) (M.I.)

I agree that the practice may communicate with me electronically at the following address:

_____ _____

Phone Number E-mail Address *(please print)*

I consent to receive calls and text messages related to my protected healthcare and other services at the phone number(s) above, including my wireless number provided. I understand I may be charged for such calls by my wireless carrier and that such calls may be generated by an automated dialing system.

Do we have your permission to:

Send a recall appointment reminder to your home? Yes _____ No _____

Leave appointment, billing or dental information on
Your answering machine/voice mail/e-mail: Yes _____ No _____

I give permission to share appointment, billing or dental information with the person named below:

Name: _____

_____ _____

Signature of Patient/Parent or Legal Guardian Date

If signed by other than patient, specify relationship to patient: _____

Acknowledgment of Receipt of Notice of Privacy Practices

I, _____ have received a copy of this office's Notice of Privacy Practices.

_____ _____

Signature of Patient/Parent or Legal Guardian Date

If signed by other than patient, specify relationship to patient: _____

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:

☐ Patient / Parent or Legal Guardian refused to sign form

☐ Other

_____ _____

Signature of Office Manager Date

Email Form to: info@wecaredentalsc.com