Wellis
FamilyDentistry

PATIENT INFORMATION

First Name: _____ M.I. _____ Last Name: _____ Preferred Name: _____

Sex: ☐F ☐M Date of Birth: _____ Soc. Sec.#: _____ Driver's Lic.#: _____

Email (for appointment reminders): _____

Address: _____ City: _____ State: _____ Zip: _____

Hm #: _____ Wk #: _____ Ext. _____ Cell: _____

Patient Employer: _____ Present Position: _____ How long held: _____
(Parent if Minor)

Referred by: ☐Phonebook ☐Website ☐Location ☐Patient: _____ ☐Other: _____

In case of emergency who should be notified? _____ Phone: _____

Who will be responsible for the account? ☐Self (if self you don't need to fill out this section) ☐Spouse ☐Father ☐Mother ☐Other_____

Name: _____ Soc. Sec. # _____ D.L.# _____

Date of Birth: _____ Hm #: _____ Cell #: _____

Address: _____ City: _____ State: _____ Zip _____

Employer: _____ Tel #: _____

METHOD OF PAYMENT: Payment in full or estimated insurance co-payment is to be paid in full at each appointment.
I will pay today's charges in full by: ☐ Cash ☐ Check ☐ Credit Card ☐ Other ☐ Financing

*ALL UNPAID CHARGES WILL BE SUBJECT TO FINANCE CAHRGES, ADMINISTATION FEES AND LEGAL COSTS INCURRED DURING COLLECTIONS

Insurance Information

Patient relationship to policy holder:

___Self ___Spouse/Partner ___Dependent

Dental Insurance- 1st Coverage

Policy Holder _____

Policy Holder Date of Birth _____

Name of Insurance Co. _____

Address _____

Telephone _____

I.D or policy # _____

Group # _____

Dental Insurance- 2nd Coverage

Policy Holder _____

Policy Holder Date of Birth _____

Name of Insurance Co. _____

Address _____

Telephone _____

I.D or policy # _____

Group # _____

Smile Evaluation

Please circle answer

Do you have specific dental problems? Yes No

If yes, please explain _____

Do you have dental examinations on routine basis Yes No

Do you brush and floss daily? Yes No

Do your gums ever bleed? Yes No

Do you like the appearance of your teeth? Yes No

Are your teeth all in alignment (straight)? Yes No

Do you have spaces you don't like? Yes No

Do you like the color of your teeth? Yes No

Are there old fillings or dental work you don't like looking at? Yes No

Do you ever have clicking/popping/discomfort in the jaw joint? Yes No

Do you clinch or grind your teeth? Yes No

Have your past dental experiences been positive? Yes No

Do you smoke or chew? Yes No

Do you snore? Yes No

Have you ever been treated for gum disease? Yes No

Name of previous dentist: _____

When was the last time you had a full mouth series of x-rays taken? _____

When is the last time you had your teeth cleaned? _____

Patient Name:_____ **D.O.B.:**_____

Medical information

Reason for today's office visit:

_____

Name of your Physician:

_____

Phone:_____

Have you had any illness, operation or been hospitalized in the past five years?

_____

_____

Are you taking any medication?___Y___N

Please List

_____

_____

_____

_____

Are you allergic to any medications or substances?

☐ Latex ☐Penicillin ☐Codeine ☐Sulfa ☐Aspirin ☐Acrylic ☐Metal ☐Other_____

Women

Pregnant/trying to get pregnant Y☐ N☐
Nursing Y☐ N☐
Taking oral contraceptives Y☐ N☐

Health History

Please circle answer

Heart Trouble/Disease	Yes	No	Irregular Heart Beat	Yes	No
Angina/ Chest Pain	Yes	No	Heart Attack/ Failure	Yes	No
Congenital Heart Disorder	Yes	No	Mitral Valve Prolapse	Yes	No
Heart Murmur	Yes	No	Anemia	Yes	No
Scarlet Fever	Yes	No	Artificial Heart Valve	Yes	No
Heart Pace Maker	Yes	No	Heart Surgery	Yes	No
High Blood Pressure	Yes	No	Blood Disease	Yes	No
Tuberculosis	Yes	No	Diabetes	Yes	No
Epilepsy/ Seizure	Yes	No	Asthma	Yes	No
Rheumatic Fever	Yes	No	Artificial joint, prosthesis	Yes	No
Shortness of Breath	Yes	No	Sickle Cell Disease	Yes	No
Leukemia	Yes	No	Recent Blood Transfusion	Yes	No
Chemotherapy	Yes	No	Lung Disease	Yes	No
Emphysema	Yes	No	Cancer	Yes	No
Ulcers	Yes	No	Excessive Thirst	Yes	No
Liver Disease	Yes	No	Hepatitis A (infectious)	Yes	No
Hepatitis B or C	Yes	No	Pain in Jaw Joints	Yes	No
Cortisone Medicine	Yes	No	AIDS	Yes	No
HIV Positive	Yes	No	Drug Addiction/Alcoholism	Yes	No
Kidney Problems	Yes	No	Renal Dialysis	Yes	No
Thyroid Disease	Yes	No	Stroke	Yes	No
Cold Sores/Fever Blisters	Yes	No	Fainting or Dizziness	Yes	No
Tumors or Growths	Yes	No	Nervousness	Yes	No
Psychiatric Care	Yes	No	Alzheimer's Disease	Yes	No
Allergies (Medicines)	Yes	No	Allergies (Pollen/Dust)	Yes	No
Need Premedication?	Yes	No	Sleep Apnea	Yes	No

Have you ever had any serious illness not listed above?

_____

Do you wish to talk to the dentist privately about anything?

_____

I Certify that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquires set forth above have been answered to my satisfaction. I will not hold my dentist, or any member if his/her staff responsible for any errors or omissions that I have made in the completion of this form.

Signature of Patient:
(Parent or Guardian if minor) **X**_____ **Date:** _____

Fees & Payment

We make every effort to keep down the cost of your dental treatment. You can help by paying upon completion of each visit. An estimate of the charge for any procedure you may require will be given to you upon request. If you have dental insurance we will be glad to fill out the proper forms and file them, but please complete the identifying information on this form.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance company. You will be responsible for all collection costs, attorneys' fees, and court costs.

Signature of Patient:
(Parent or Guardian if minor) **X**_____ **Date:** _____

Release of Information & Assignments of Benefits

This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to this doctor named of the benefits otherwise payable to me.

Signature of Patient:
(Parent or Guardian if minor) **X**_____ **Date:**_____

Nellis Family Dentistry
Nicole A. Nellis, DDS, PLLC

OFFICE POLICIES

Broken/Cancelled Appointments: We are very appreciative of patients who arrive on time for their schedueld appointments. In the event you need to cancel an appointment, we request notice at least 24 hours in advace of the appointment. As a courtesy, our office may contact you via email or phone to remind you of the appointment(s). While certain emergencies an other issues may be taken into consideration, Nellis Family Dentistry reserves the right to apply a fee of $25 per half-hour of the scheduled appointment for failure to provide adequate notice.

Guarantee of Payment/Assignment of Insurance Benefits: Unless otherwise stated, I understand that fees are due for any services rendered on the date of service. I authorize payment for services rendered to me to be made directly to this office for benefits otherwise payble to me. These payments shall not exceed the regular charges for this period of treatment. I also understand that I am respoinsible to pay any charges not covered through my insurance benefits, including but not limited to non-covered services, applicable deductible and/or co-insurances as defined by my policy(ies), or, any fees for services in the event that I do not have insurance coverage.

Completion of Treatment: In the event that I elect to receive treatments such as crowns, dentures, root canals, bridges, implants, and other treatment that requires me to return for future visits to finalize, I understand that I am responsible to return to the office to complete treatment. These types of treatments typically require Nellis Family Dentistry to incur lab, equipment, and labor costs up front. In the event that I do not return to complete the treatment, I understand that I am still responsible to pay the full cost of the treatment.

Past Due Balances & Collection Services: Nellis Family Dentistry makes an effort to provide all patients with education and information regarding proposed and completed treatment as well as the costs associated, in order for each patient to make an informed decision regarding their treatment. Nellis Family Dentistry also participates in lending programs to extend interest-free credit to qualified applicants for certain procedures. However, in the event that I do not pay outstanding balance(s), I understand that a 12% interest rate will be applied to any past due balance(s) on my account(s). I also understand that should my past due balance be referred to an attorney or collection agency, I will be financially responsible for any additional costs incurred such as attorney fees, collection agency fees, court costs, etc.

Patient Dismissal: Our practice takes pride in our dentistry and the relationships with our patients who believe in quality care. Cooperation is a key element to successful treatment. Nellis Family Dentistry reserves the right to dismiss patients in the interest of customer service and quality of care for all patients. Nellis Family Dentistry will be happy to transfer patient records to another provider at the request and approval of any patients who are dismissed.

I agree to abide by the policies listed above. I understand that if I have any questions about these policies, I may request assistance and further explanation at any time from a Nellis Family Dentistry staff member.

_____ _____

Patient/Responsible Party Name Date

_____

Patient/Responsible Party Signature

_____ _____

Nellis Family Dentistry STAFF Witness Date

Nellis Family Dentistry
Nicole A. Nellis, DDS, PLLC

Acknowledgement of Receipt of Notice of Privacy Practices

I, _____ have received a copy of this Nellis Family Dentistry Notice of Privacy Practices.

Alternate Communications Information

Nellis Family Dentistry normally contacts patients using phone or email for appointment reminders, account information, pre-medication information, and other information pertaining to your treatment or account.

If you will need **Nellis Family Dentistry** to observe alternate methods to contact you other than what you have listed, please list them below, otherwise, leave this section blank:

- ☐ Phone: (Number) _____ May we leave a message? _____ Yes _____ No
  - o May we leave a message regarding pre-medication if necessary? _____ Yes _____ No
- ☐ Mail: (Address) _____
- ☐ Email: (Address) _____
- ☐ Other: (Please list) _____

When leaving a message, please list your preference for how **Nellis Family Dentistry** identifies itself:

_____ Nellis Family Dentistry _____ Dentist's office _____ None _____ Other: _____

_____ _____

Patient/Responsible Party Signature **Date**

For Office Use Only

_____ _____

Nellis Family Dentistry STAFF Witness **Date**

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

- ☐ Individual refusal to sign
- ☐ Communications barrier prohibited the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (please specify) _____