IMPRESSIONS DENTAL
Renalla K. Ellis, DDS
2510 E. Independence, #600 • Shawnee, OK 74804
405/273-2002 • Fax 405/273-0087
smileshawnee.com

Please read carefully and fill out completely, including all insurance information.

Patient Information

Name _____ *Married* ___ *Single* ___ *Divorced* ___ *Other* _____

Address _____ *City* _____ *State* _____ *Zip* _____

Birthday _____ *Soc. Sec.* _____ *M* ____ *F* ____ *Home Phone* _____

Employer _____ *Work Phone* _____ *Ext.* _____

E-mail address _____ @ _____ *Cell Phone* _____

Person responsible for this account: Name _____

If different from above

Married ___ *Single* ___ *Divorced* ___ *Parent* ___ *Step Parent* ___ *Birthday* _____ *Soc. Sec.* _____

Address _____ *City* _____ *State* _____ *Zip* _____ *Phone* _____

Employer _____ *Work Phone* _____ *Ext.* _____

Address _____ *City* _____ *State* _____ *Zip* _____

E-mail address _____ @ _____ *Cell Phone* _____

How did you hear about our office: _____

Person with Primary Insurance: Name _____

Spouse ___ *Parent* ___ *Ex husband* ___ *Ex wife* ___ *Other* ___ *Birthday* _____ *Soc. Sec.* _____

Employer _____ *Phone* _____ *Ext.* _____ *Cell Phone* _____

Ins. Name _____ *Group* _____ *Phone* _____

Are children covered on this policy? If yes, please list names _____

Person with 2ndary Insurance: Name _____

Spouse ___ *Parent* ___ *Ex husband* ___ *Ex wife* ___ *Other* ___ *Birthday* _____ *Soc. Sec.* _____

Address _____ *City* _____ *State* _____ *Zip* _____ *Phone* _____

2ndary Insurance Company: _____

Are you on this insurance also? ___ *Yes* ___ *No* *Group* _____ *Phone* _____

Are children covered on this policy? If yes, please list names _____

Patient Name _____ *Date* _____ /_____/_____

Health Information *Please check if you have or ever had any of the following.*

___ *Arthritis*	___ *Excessive Bleeding*	___ *Mental Disease*	___ ***Heart Disease***
___ ***Artificial Joints***	___ *Head Injuries*	___ *Nervousness*	___ ***Heart Murmur***
___ *Asthma*	___ ***Hepatitis***	___ *Rheumatism*	___ ***High Blood Pressure***
___ *Cancer*	___ ***HIV/AIDS***	___ *Sinus Problems*	___ ***Miltral-valve Prolapse***
___ *Diabetes*	___ *Kidney Disease*	___ *Stomach Problems*	___ *Pacemaker*
___ *Epilepsy*	___ *Liver Disease*	___ *Tuberculosis*	___ *Stroke*

Physician's Name _____ *Phone* _____ /_____

Are you under medical treatment now? ___*Yes* ___*No*

If yes, please explain _____

Have you been hospitalized for any surgical operation or serious illness within the last 5 years? ___*Yes* ___*No*

If yes, please explain _____

Are you taking any medications including any non-prescription medicine? ___*Yes* ___*No*

If yes, please list _____ _____

Have you ever taken Phen-Phen, Redux? ___*Yes* ___*No* *Do you use any controlled substances?* ___*Yes* ___*No*

Have you ever taken Fosamax, Boniva for osteoporosis or other? ___*Yes* ___*No*

Women Only: *Are you pregnant?* ___*Yes* ___*No* *Week #* _____

Please check if you are allergic to any of the following:

___ *Local Anesthetics*	___ *Aspirin*	___ *Codeine*	___ *Any metals (e.g. nickel, mercury, etc.)*
___ *Barbiturates*	___ *Latex rubber*	___ *Penicillin*	
___ *Sedatives*	___ *Sulfa Drugs*	___ ***Other*** *(please list)* _____	

Dental History

Reason for today's visit _____ *Date of last cleaning?* _____ /_____ / _____

Previous Dentist _____ *Why did you leave?* _____

What did you like about your last dentist? _____

Do you use tobacco? ___*Yes* ___*No* *Would you be interested in a simple and inexpensive way to whiten your teeth?* ___*Yes* ___*No*

If you could change anything about your smile, what would it be? _____

Please check if you have problems with any of the following:

___ *Clicking / popping jaw*	___ *Bad Breath*	___ *Bleeding Gums*	***Check if your teeth are sensitive to:***	
___ *Food catching in teeth*	___ *Gum Treatment*	___ *Grinding Teeth*	___ *Cold*	___ *Heat*
___ *Loose / broken fillings*	___ *Sores / growths*		___ *Sweets*	___ *Pressure*

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency *dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed. Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he/she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by the insurance company.*

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay, therefore, the reasonable value of said services to said doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing, if credit shall be extended. I further agree that the reasonable value of said services shall be billed unless objected to by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term of condition and further term or condition and further agree to pay all cost and reasonable attorney fees if suit be unsuited hereunder.

I grant my permission to you or your assigned, to telephone me at home or at work to discuss matters related to this form. I also agree to authorize release of any information including diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners.

Signature of Patient or Guardian _____ ***Date*** _____/ _____ / _____