



LASER

DENTISTRY

Dr. James M. Ellis, D.D.S.

706 39th Street West
Bradenton, FL 34205
941.748.0660

Welcome to Our Office!

Name		SS#	
Address			
City		State	Zip
Phone	Sex	Age	Birthdate
Employer		Occupation	
Employer Phone	Work Phone	Cell Phone	
Referred by			
Notify in Case of Emergency		Phone	

Insurance Information

Policy Holder's Name			
Relationship to Patient		DOB	SS#
Address if different than patient			
Phone	Employer		Occupation
Insurance Company			Phone
Insurance Address		City	State Zip
Insurance ID #		Group #	

Secondary Insurance

Subscriber's Name			
Relationship to Patient		DOB	SS#
Address if different than Patient			
City	State		Zip
Subscriber Employed by			Phone
Insurance Company			SS#
Group ID #		Subscriber #	

To the best of my knowledge, the foregoing questions have been accurately answered. I understand that this information will be used by the Dentist to help determine appropriate and healthful dental treatment. If there is any change in my health status, I will inform the Dentist. I authorize my insurance company to pay all benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize the Dentist to release all information necessary to secure payment of these benefits. I understand that I am financially responsible for all charges, whether or not paid by my insurance company.

Please call at least 18 hours prior to you appointment date to change or cancel your visit.
No show for appointments, no call to cancel, will incur a fee of \$62.00

Signature		Date
Print Name		
If other than Patient, indicate relationship		



Medical History

Patient Name _____

Date _____

The following information is essential for this office to provide dental care in a manner that is compatible with your general health. Your cooperation in providing accurate information is necessary to meet your dental needs safely and efficiently.

Incorrect information can be dangerous to your health.

- All questions must be answered in the space provided.
- If the question is not understood, please discuss the matter with us.

Are you currently under the care of a physician?

Name & Location _____

Are you currently taking any medication?

If yes, what medication & for what reason _____

Do you need to pre-medicate before a dental visit?

What medication? _____

Are you currently having any dental problems?

Do you currently wear partial/denture?

If so, how old? _____

HAVE YOU EVER BEEN TREATED FOR : (please **circle** your condition below)

1. Glaucoma or other eye disorder? _____
2. Heart trouble, Heart Attack, Angina, Heart Surgery, Pacemaker/Irregular Heart Beat? _____
3. Thyroid, Diabetes, Stomach or Intestinal disease? _____
4. Abnormal Blood Pressure, Excessive Bleeding or Anemia? _____
5. Breathing problems, Asthma, Tuberculosis, Sinus Pain or Allergies? _____
6. Cancer, Tumors or growths, X-ray treatments or Chemotherapy? _____
7. Hepatitis, Jaundice or Liver disease? _____
8. Kidney problems or Renal disease? _____
9. Venereal disease, HIV, AIDS or Lupus? _____
10. Stroke, Convulsions or Fainting Spells? _____
11. Arthritis, Rheumatism or Artificial Joint Replacement? _____
12. Rheumatic Fever, Rheumatic Heart disease? _____
13. Heart Murmur, Mitral Valve Prolapse or Congenital heart disease? _____
14. **Allergic reactions to medications?** _____
15. Have you ever had a major operation? If yes, describe _____
16. Have you ever had a serious head/neck injury? If yes, describe _____
17. Are you on a special diet? If yes, describe _____
18. Have you had unexplained weight loss of 10 lbs. in the last two years? _____
19. Are there any other health problems of which you are aware? _____
20. Are you pregnant? _____ Nursing? _____ Taking birth control? _____