Lexi Me Her-Ellison, DDS
1222 N Douty St. Hanford, CA 93230 (P) 559-582-2827 herellisondds@gmail.com

DENTAL REGISTRATION AND HISTORY

PATIENT INFORMATION

Patient Name: _____ Today's Date: _____

Social Security#: _____ Birth Date: _____ E-mail: _____

Address: _____

City: _____ State:_____ Zip:_____

Phone#: Home: (_____)_____ Work: (_____)_____Cell: (_____)_____

Sex: □ M □ F □ Single □ Married □ Widowed □ Separated □ Divorced

Occupation _____Employer _____Employer Phone# (_____)_____

Guardian/Spouse Name: _____ SS#:_____ Birth date:_____

Guardian/Spouse Occupation: _____ Employer: _____

Guardian/Spouse Phone#: (_____)_____Spouse's Cell #: (_____)_____

Emergency Contact: _____Relationship to Patient:_____
(Please specify someone who does not live in your household)

Emergency Contact Home #: (_____)_____ Cell#: (_____)_____

Whom may we thank for referring you to our office?_____

DENTAL HISTORY

Reason for today's visit: _____ Former Dentist: _____

Former Dentist Phone# _____ Former Dentist City/State: _____

Date of last dental visit: _____ Date of last dental X- rays: _____

For each item, check " yes" or " no" to indicate if you have or have had any of the following:

Bad breath	□ yes □ no	Bleeding gums	□ yes □ no
Blisters/cold sores on lips or mouth	□ yes □ no	Burning sensation on tongue	□ yes □ no
Chew on one side of mouth	□ yes □ no	Chewing/smoking/vaping of Tobacco	□ yes □ no
Clicking or popping jaw	□ yes □ no	Infection in gums or bone (abcess)	□ yes □ no
Dental anxiety/fear	□ yes □ no	Fingernail biting	□ yes □ no
Food collection between teeth	□ yes □ no	Foreign objects in mouth or throat	□ yes □ no
Geographic Tongue	□ yes □ no	Grinding/clenching teeth	□ yes □ no
Gums swollen or tender	□ yes □ no	Jaw pain or soreness	□ yes □ no
Lip or cheek burning	□ yes □ no	Loose teeth/broken fillings	□ yes □ no
Mouth breathing	□ yes □ no	Mouth pain	□ yes □ no
Oral Cancer	□ yes □ no	Orthodontic treatment (Braces)	□ yes □ no
Pain around ear	□ yes □ no	Periodontal treatment	□ yes □ no
Recurring headaches	□ yes □ no	Root canal treatment	□ yes □ no
Sensitivity to cold/hot	□ yes □ no	Sensitivity to sweets	□ yes □ no
Sensitivity when biting	□ yes □ no	Sores or growths in mouth	□ yes □ no

How often do you floss? _____ How often do you brush? _____
How often do you eat or drink acidic/sweet foods (soda, lemons, candy, etc.)? _____

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HEALTH HISTORY

Patient Name: _____

Primary Physician's Name and Phone #: _____**Date of last visit:** _____

For each item, check "yes" or "no" to indicate if you have or have had any of the following:

AIDS/HIV	□ yes □ no	Fainting/ Dizziness	□ yes □ no	Psychiatric Care	□ yes □ no
Anemia	□ yes □ no	Glaucoma	□ yes □ no	Respiratory Disease/ COPD/ Emphysema	□ yes □ no
Arthritis/Rheumatism	□ yes □ no	Head/Neck Trauma	□ yes □ no	Rheumatic Fever	□ yes □ no
Artificial Heart Valves	□ yes □ no	Heart Attack	□ yes □ no	Shortness of Breath	□ yes □ no
Artificial Joints	□ yes □ no	Heart Murmur	□ yes □ no	Sinus Trouble	□ yes □ no
Asthma	□ yes □ no	Heart Problems	□ yes □ no	Special Diet	□ yes □ no
Back Problems	□ yes □ no	Hepatitis Type___	□ yes □ no	Snoring	□ yes □ no
Bleeding Abnormally	□ yes □ no	Herpes	□ yes □ no	Stroke	□ yes □ no
Blood Thinners	□ yes □ no	High Blood Pressure	□ yes □ no	Swollen Feet or Ankles	□ yes □ no
Cancer	□ yes □ no	Jaundice	□ yes □ no	Swollen Neck Glands	□ yes □ no
Chemotherapy/ Radiation	□ yes □ no	Kidney Disease	□ yes □ no	Thyroid Problems	□ yes □ no
Circulatory Problems	□ yes □ no	Liver Disease	□ yes □ no	Tonsillitis	□ yes □ no
Cold Sores	□ yes □ no	Low Blood Pressure	□ yes □ no	Tuberculosis	□ yes □ no
Cortisone/Steroids	□ yes □ no	Nervous/ Psychological Problems	□ yes □ no	Tumor or Growth on head/neck	□ yes □ no
Cough, persistent or bloody	□ yes □ no	Organ Transplant	□ yes □ no	Ulcer	□ yes □ no
Diabetes Type____	□ yes □ no	Osteoporosis	□ yes □ no	Venereal Disease	□ yes □ no
Epilepsy	□ yes □ no	Pacemaker	□ yes □ no	Weight Loss, Severe	□ yes □ no

1.) Have you been hospitalized in the last 5 years? □ yes □ no If yes, please list dates and reason:
_____

2.) Have you ever taken any of the group of drugs collectively referred to as bisphosphonates for osteoporosis or bone health (Dexfenfluramine, Fasomax, Actoul, Boniva, Zometa, Aredia)? □ yes □ no

3.) Have you ever taken Phen Fen or other related diet and weight loss pills? □ yes □ no

4.) Do you snore, have excessive daytime tiredness, or been diagnosed with sleep apnea? □ yes □ no

5.) For females, are you currently pregnant or breastfeeding? □ yes □ no

6.) Any other medical/dental conditions that we should be aware of? □ yes □ no
Please list: _____

MEDICATIONS

List any medications you are currently taking, the dosage, and the correlating diagnosis (if not enough room, please provide entire list):

Medication	Dosage	How Often	Condition

IF NONE, PLEASE CHECK THIS BOX ☐

ALLERGIES

☐ **Aspirin** ☐ **Local Anesthetic**
☐ **Barbiturates** ☐ **Penicillin**
(Sleeping pills) ☐ **Sulfa**
☐ **Codeine** ☐ **Other**_____
☐ **Iodine** _____
☐ **Latex**

IF NONE, PLEASE CHECK THIS BOX ☐

By signing below, I certify that the information contained in this medical history, dental history, and release form is true and correct to the best of my knowledge. I give my consent for initial treatment which may include exam, x-rays, impressions, photos or emergency treatment as prescribed to me by Dr. Her-Ellison and/or her associates. Every reasonable effort will be made to ensure that my condition is treated properly.

Patient/Guardian Signature X _____ **Date:**_____

Reviewing Dentist Signature X_____**Date:**_____

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Dental Insurance Information

Patient Name:_____ **Date of Birth:**_____
Person financially responsible for account (Guardian if minor): _____

Will you be utilizing dental insurance? □ yes □ no
If yes, please provide the following information along with a copy of your dental benefit card(s).

Dental Insurance Plan #1:

Dental Insurance Company:	Group #:
Subscriber's Name:	Subscriber's SSN/ID:
Relationship to Patient:	Subscriber's Birth date:

Dental Insurance Plan #2:

Dental Insurance Company:	Group #:
Subscriber's Name:	Subscriber's SSN/ID:
Relationship to Patient:	Subscriber's Birth date:

Financial Policy

Dental insurance plans are designed to help with **PART** of your dental expenses and may not always cover every dental need. Dental plans and their benefits are an agreement between you or your employer/ group and the dental plan company. The dental office has no control over your plan benefits and coverages. The typical plan includes limitations and exclusions as well as copayments and deductibles that must be paid before your dental benefits will go into effect. This can relate to the type or number of procedures, the number of visits or age limits. These limitations, exclusions, and copayments are carefully detailed in the plan booklet and warrant your attention. Plan booklets can be obtained from your employer's human resources or from the dental company that services your plan.

Copayments and deductibles are due at the time of service unless a signed financial arrangement is made ahead of time. **The American Dental Association Code of Ethics prevents any dentist from waiving copayments and/or deductibles when utilizing a dental insurance plan.** Our office offers many payment options to help cover your dental expenses. Please ask any staff member if you are interested in hearing more about our payment options.

ASSIGNMENT & RELEASE

I, the undersigned, certify that I (or my dependent) have dental coverage with the above listed plan(s) and assign directly to Dr. Me Her-Ellison all benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not my dental insurance plan pays. I understand that any outstanding amounts owed after 90 days will be sent to a collections agency. Any additional fees for collections will also be my responsibility. I agree to inform the office of any changes in dental insurance plan or coverage as soon as possible. I hereby authorize the doctor and/or her representatives to release the use of this signature on all dental insurance plan admissions and/or claims.

_____
Print Name (or Guardian Name if minor)

X_____ _____
Patient (Or Guardian) Signature **Date**

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Acknowledgements

Patient Name:_____ **Date of Birth:**_____

_____ **(Initials)** I, the undersigned, consent to the office of Dr. Her-Ellison and/or her representative using my cell phone number(s), home or work phone number(s), email, and address listed in my patient chart to call, text, or mail regarding appointments, treatment, dental benefits, and my family account balance. I agree that messages/ mail may be sent to or left for me at these numbers, email, or address.

_____ **(Initials)** I consent to Dr. Her-Ellison and/or her representatives rendering emergency medical treatment to me and/or my dependent as necessary in the event that it is needed if I am unable to give consent. The office is equipped with emergency medications, supplies, an oxygen tank, and an automated external defibrillator (AED) and I understand any of these may be used in case of an emergency situation.

_____ **(Initials)** I, the undersigned, understand that photos, X rays, impressions, models, audio recordings, videos, writing, and other media ("records") may be taken of me and my dependents while in the office or at an office sponsored event. I authorize Dr. Her-Ellison and/or her representatives to share these records with outside vendors and persons to better serve my treatment needs, obtain insurance payments, as educational tools, or in connection with Dr. Her-Ellison and her dental office. I understand that my records may also be shared with other professionals in an educational setting or used for advertising, on websites, social media, or any other media. If used, I understand that every effort will be made to remove unnecessary identifying information and my name will be kept confidential. I do not expect compensation, financial or otherwise, for the use of these records in the manner described. I understand that I may revoke this release at anytime with written notice.

_____ **(Initials) CANCELLATION POLICY:** We appreciate you and your family trusting us with your dental needs. To ensure that all of our patients receive excellent treatment in a timely manner, your appointment time is reserved specifically for you and the treatment that will be completed. As such, it is expected that you will make all of your appointments at the time they are scheduled. You will receive courtesy reminders via text to the cell phone number provided or a call 1-2 business days before your appointment. **If you need to reschedule or cancel your appointment, please contact our office at least 24 hours ahead of your appointment. Failure to do so will result in a $50 missed appointment/ late cancellation fee that must be paid before another appointment is made.** For your convenience, you may leave a message at (559) 582-2827 at anytime.

_____
Print Name (or Guardian Name if minor)

X_____ _____
Patient (Or Guardian) Signature **Date**

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Acknowledgement of Receipt of Notice of Privacy Practices

You may refuse to sign This Acknowledgement

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

Patient/Guardian Signature:_____ Date:_____

Patient Acknowledgement of Receipt of Dental Materials Fact Sheet

I, _____(print name), on _____ (date), acknowledge I have received, from the office of Dr. Me Her-Ellison, a copy of the Dental Materials Fact Sheet.

_____
Patient/Guardian Signature

The following document is the Dental Board of California's Dental Materials Fact Sheet. The Department of Consumer Affairs has no position with respect to the language of this Dental Material Fact Sheet; and its linkage to the DCA website does not constitute an endorsement of the content of this document.

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:

- ☐ Individial refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please specify):_____

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Consent To Disclose Information

Our office will not share your protected health or account information with persons other than as outlined in our Notice of Privacy Practices.

If you want to allow our office to speak to other persons such as a spouse, step-parent, grandparent, or other adult regarding you or your dependents' dental and account related concerns, including treatment, costs, and making appointments, please list their names and relation to the patient below.

For example, if you would like to have a grandparent bring your child to their appointment or allow us to discuss your treatment or financial information with your spouse, please list them below. By signing below, you are authorizing the listed persons to consent to emergency medical treatment for you or your child if you are not able to do so.

1. Name:_____ Relation to patient:_____

2. Name:_____ Relation to patient:_____

3. Name:_____ Relation to patient:_____

X_____ _____
Patient/Guardian Signature **Date**