JOSEPH R. WELLS, D.D.S.
SUZANNE B. ERSKINE, D.D.S.
ROBERT W. HAWKINSON, D.D.S., M.S.

NAME____ DATE ______________
ADDRESS____
CITY__________________________________ STATE ______ ZIP____________
Phone: Home _________________________ Work__________________________
Cell __________________________ General Dentist ________________________
Social Security # _________________________ Date of Birth_________________
Person Responsible for Payment ____
Address____
SS#____

HEALTH QUESTIONS	YES	NO
Is your general health good?	☐	☐
Are you under a physician's care now?	☐	☐
Have you ever had: Heart trouble, rheumatic heart disease, joint replacement, diabetes, high blood pressure, hepatitis, cancer? Please circle.	☐	☐
Are you HIV positive or do you have AIDS?	☐	☐
Have you ever had a bleeding problem?	☐	☐
Have you had surgery within the past six years?	☐	☐

Have you ever had an allergic reaction to any drug or local anesthetic?
Name ____

Is there any information about your health which should be known?	☐	☐

List any prescription drugs you are taking.
____

I understand that only the root canal treatment is to be done at this office. The permanent (outside) restoration (filling, crown, bridge, etc.) will be done by my regular dentist.

SIGNED ____

DENTAL Primary Ins.____

INSURANCE ADDRESS ____
____

GROUP# _________________________ PHONE #__________________________
EMPLOYER NAME ____
ADDRESS ____________________________PHONE #______________________
EMPLOYEE NAME ____
RELATIONSHIP TO PATIENT _____________________________________
BIRTH DATE ________________ SS or ID ______________________________

DENTAL Secondary Ins. ____
INSURANCE ADDRESS ____
GROUP# _________________________ PHONE #__________________________
EMPLOYER NAME ____
ADDRESS ____________________________PHONE #______________________
EMPLOYEE NAME ____
RELATIONSHIP TO PATIENT _____________________________________
BIRTH DATE ________________ SS or ID ______________________________

PLEASE SIGN FOR AUTHORIZATION OF PAYMENT

☐ I hereby authorize payment to Drs. Joseph R. Wells, Suzanne B. Erskine, and Robert W. Hawkinson
I understand that I am financially responsible for any charger not covered by my insurance. I authorize the release of any information relating to this claim.

☐ I have no insurance; therefore, I am financially responsible for charges

____ ______________________
SIGN Date

*JOSEPH R. WELLS, D.D.S. *ROBERT W. HAWKINSON, D.D.S., M.S.
*SUZANNE B. ERSKINE, D.D.S.

PATIENT CONSENT FORM

I have been informed of, and given the right to review and secure, a copy of your "Notice of Privacy Practices" These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPPA). I understand that by signing his consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payers (e.g. my insurance company)
- The day-to-day healthcare operation of your practice

I understand I may revoke this consent, in writing, at any time. We may decline to treat you or to continue treating you if you revoke this consent.

Print Name ____________________________________ Date ____________

Signature____

Relationship to Patient ____

____