JOE M. ELLIS DDS

Welcome to our environment. It is our mission to provide a warm and caring place where we come together to enhance health and well-being through relationships based on respect, understanding, and excellence in care, skill and judgment. Please help us begin by completing the questionnaire below. If you should have any questions, I or my staff are at your service.

Last name:	First and Middle:
What name would you like us to use?	
Home #:	Business #:
Fax#:	Cell#:
Address:	City St. Zip:
EMAIL:	Other:
Emergency Contact Name:	Phone #:
Are You: Married? Single? Divorced? Separated? Widowed?	
Name of Employer:	Present Position:
Date of Birth:	Social Security#:
Who referred you to us?	
Person responsible for payment:	

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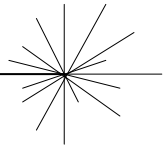

Please check all applicable:

	Concern?	Location / Area
Bleeding Gums	☐	
TMJ Problems	☐	
Frequent Headaches	☐	
Chipped Teeth	☐	
Worn Edges	☐	
Loose Teeth	☐	
Rough Areas	☐	
Food Traps	☐	
Unusual Odor or Taste	☐	
Discolored Teeth	☐	
Poor Tooth Alignment	☐	
Missing Teeth	☐	
Implants	☐	
Old Fillings or Crowns	☐	
Crowding	☐	
Orthodontics	☐	
Bite Problems	☐	
Sensitive Teeth	☐	
Sensitive to:		
Other:	☐	

Main Concern: _____

I certify that the above statements are correct and authorize release of any information relating to my treatment in this office.

Signature: _____ Date: _____