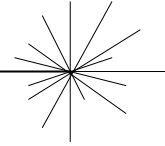




JOE M. ELLIS DDS

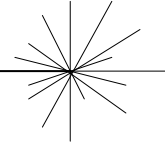


Welcome to our environment. It is our mission to provide a warm and caring place where we come together to enhance health and well-being through relationships based on respect, understanding, and excellence in care, skill and judgment. Please help us begin by completing the questionnaire below. If you 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 | <input type="checkbox"/> | _____ |
| TMJ Problems | <input type="checkbox"/> | _____ |
| Frequent Headaches | <input type="checkbox"/> | _____ |
| Chipped Teeth | <input type="checkbox"/> | _____ |
| Worn Edges | <input type="checkbox"/> | _____ |
| Loose Teeth | <input type="checkbox"/> | _____ |
| Rough Areas | <input type="checkbox"/> | _____ |
| Food Traps | <input type="checkbox"/> | _____ |
| Unusual Odor or Taste | <input type="checkbox"/> | _____ |
| Discolored Teeth | <input type="checkbox"/> | _____ |
| Poor Tooth Alignment | <input type="checkbox"/> | _____ |
| Missing Teeth | <input type="checkbox"/> | _____ |
| Implants | <input type="checkbox"/> | _____ |
| Old Fillings or Crowns | <input type="checkbox"/> | _____ |
| Crowding | <input type="checkbox"/> | _____ |
| Orthodontics | <input type="checkbox"/> | _____ |
| Bite Problems | <input type="checkbox"/> | _____ |
| Sensitive Teeth | <input type="checkbox"/> | _____ |
| Sensitive to: | | _____ |
| Other: | <input type="checkbox"/> | _____ |
| 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: _____