Welcome to Hilltop Family Dental

Circle One: Mr. / Mrs. / Ms. First Name:_____ M.I._____ Last Name:_____

Sex: ☐ Male ☐ Female Date of Birth:_____ Age:_____ Soc. Sec. #_____ Email:_____

Street:_____ City:_____ State:_____ Zip:_____

Home Tel. # (_____) _____ Bus. Tel. # (_____) _____ Ext:_____ Employer:_____

Occupation:_____ Medical Doctor:_____ Referred by:_____

Driver's Lic. #_____ Nearest relative not living with you:_____ Tel. # (_____) _____

Have you ever been a patient of our practice? ☐ Yes ☐ No Method of Personal Payment: ☐ Cash ☐ Check ☐ Credit Card

Who will be responsible for your account? ☐ Self ☐ Spouse ☐ Father ☐ Mother ☐ Other _____
(if self, skip to next paragraph)

Name:_____ Soc. Sec. # _____ Home Tel. # (_____) _____

Street:_____ City:_____ State:_____ Zip:_____

Employer:_____ Tel. # (_____) _____

Spouse or other gurantor information (if different from above)

Name:_____ Relation:_____ Soc. Sec. # _____ Home Tel. # (_____) _____

Street:_____ City:_____ State:_____ Zip:_____

Employer:_____ Tel. # (_____) _____

INSURANCE INFORMATION

Patient: Student: ☐ Full Time ☐ Part Time ☐ Not School Name/Address:_____

Employed: ☐ Full Time ☐ Part Time ☐ Retired ☐ Not _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Legally Separated ☐ Widow

PRIMARY DENTAL INSURANCE COMPANY

Employer:_____

Bus. Address:_____

Bus. Tel. # (_____) _____ Plan:_____

Ins. Co. Name:_____

Address:_____

_____ Tel. # (_____) _____

Group # _____ Group Name:_____

Insured Party:_____ Relation:_____

Sex: ☐ M ☐ F Date of Birth:_____

Street:_____

City, State, Zip:_____

Tel. # (_____) _____ Soc. Sec. #_____

I.D. # _____

SECONDARY DENTAL INSURANCE COMPANY

Employer:_____

Bus. Address:_____

Bus. Tel. # (_____) _____ Plan:_____

Ins. Co. Name:_____

Address:_____

_____ Tel. # (_____) _____

Group # _____ Group Name:_____

Insured Party:_____ Relation:_____

Sex: ☐ M ☐ F Date of Birth:_____

Street:_____

City, State, Zip:_____

Tel. # (_____) _____ Soc. Sec. #_____

I.D. # _____

FEES & PAYMENTS

We make every effort to keep down the cost of your dental care. You can help by paying upon completion of each visit. Other arrangements can be made with our office manager depending upon special circumstances. An estimate of the charge for any procedure you may require will be given to you upon request. If you have any dental insurance we will be glad to fill out the proper forms, but please complete the identifying information on this form.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance company. You will be responsible for all collection costs, attorneys fees, and court costs.

This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to this doctor named of the benefits otherwise payable to me.

Signature of Patient: X _____ **Date: X** _____
(Parent or Guradian if minor)

AUTHORIZATION

I authorize my dentist and his/her designated staff, to perform an oral and maxillofacial examination, for the purpose of diagnosis and treatment planning. Furthermore, I authorize the taking of all x-rays required as a necessary part of this examiniation. In addition, if medically necessary, I authorize the release of any information acquired in the course of my examination and treatment.

Pictures taken with a photo camera can be used for patient education and teaching purposes.

Signature of Patient: X _____ **Date: X** _____
(Parent or Guradian if minor)

Health History

To our patients: Although the dentists and/or hygeinists primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the care that you will be receiving. Thank you for answering the following questions. Your answers are for our records only and will be considered confidential.

Reason for today's office visit:

	Yes	No
• Are you in good health? Height:_____ Weight:_____	☐	☐
• Have there been any changes in your general health in the past year?	☐	☐
• Are you under the care of a physician? Date of last visit:_____ If so, for what are you being treated? _____	☐	☐
• Have you had any illness, operation or been hospitalized in the past five years?	☐	☐
• Do you have unhealed injuries or inflamed areas, growths or sore spots in or around your mouth? If so describe where:_____	☐	☐
• Do you have a prosthetic joint/implant? If so describe where:_____	☐	☐
• Have you had a heart valve replacement or vascular graft?	☐	☐

HAVE YOU HAD OR DO YOU CURRENTLY HAVE...	Yes	No	NOTES	HAVE YOU HAD OR DO YOU CURRENTLY HAVE...	Yes	No	NOTES
Rheumatic fever?				Stroke?			
Damaged heart valves / mitral valve prolapse?				Thyroid trouble?			
Heart murmur?				Diabetes?			
High blood pressure?				Low blood sugar?			
Low blood pressure?				Kidney trouble?			
Chest pain, angina?				Are you on dialysis?			
Heart attack(s)?				Swollen ankles, arthritis or joint disease?			
Irregular heart beat?				Stomach ulcers?			
Cardiac pacemaker?				Contagious diseases?			
Heart surgery? Bronchitis, chronic cough?				Sexually transmitted diseases?			
Asthma?				Problems with your immune system?			
Hay fever / sinus problems?				Delay in healing?			
Tuberculosis?				A tumor or growth?			
Emphysema?				X-Ray treatment / chemotherapy?			
Difficult breathing / other lung trouble?				Chronic fatigue / night sweats?			
Do you smoke?				Are you on a diet?			
Blood transfusion?				A history of drug abuse?			
Blood disorder such as anemia?				A history of alchohol abuse?			
Bruise easily?				Contact lenses?			
Bleeding tendency (abnormal bleed)?				Eye disease / glaucoma?			
Jaundice, hepatitis or liver disease?				Mental health problems?			
Infectious mononucleosis?				A removable dental appliance?			
Gallbladder trouble?				Pain & clicking of jaws when eating?			
Fainting spells?				Malignant hyperthermia?			
Convulsions, epilepsy?							

MEDICATION

ARE YOU NOW TAKING...	Yes	No	NOTES		Yes	No	NOTES
Any kind of medicine, drugs, or pills?				Any kind of natural product, herbal supplement, or homeopathic remedy?			
Blood thinners? (i.e. Coumadin, Aspirin, Advil)				Have you ever taken diet pills? (i.e. Phen Phen or Redux)			
Tranquilizers?				**Please list any other medications you are taking:**			

ALLERGIES

ARE YOU ALLERGIC TO OR EVER HAD A REACTION TO...	Yes	No	NOTES	ARE YOU ALLERGIC TO OR EVER HAD A REACTION TO...	Yes	No	NOTES
Local anesthetics?				Codeine or other narcotics?			
Penicillin?				Other medications?			
Other antibiotics?				Latex?			
Sodium pentothal, valium, or other tranquilizers?				**Please list any allergies other than drug allergies:**			
Aspirin / Ibuprofen?							

WOMEN

Is there a possibility of pregnancy?				Are you nursing?			
Estimated delivery date: ____/____/____				Are you taking birth control pills?			

WOMEN NOTE: Antibiotics (such as penicillin) may alter the effectiveness of birth control pills.
Consult your physician / gynecologist for assistance regarding additional methods of birth control.

IS THERE ANY CONDITION CONCERNING YOUR HEALTH THAT THE DOCTOR SHOULD BE TOLD? ☐ Yes ☐ No

Do you wish to speak to the doctor privately about anything? ☐ Yes ☐ No

Is there a family history of: Cancer: ☐ Yes ☐ No Diabetes: ☐ Yes ☐ No Heart Disease: ☐ Yes ☐ No Anesthetic Problems: ☐ Yes ☐ No

IN CASE OF EMERGENCY, CONTACT: Name:_____ Home Tel. # (_____) _____ Work Tel. # (____) _____

IS THIS VISIT RELATED TO AN ACCIDENT? Auto: ☐ Yes ☐ No Work Related: ☐ Yes ☐ No Other: ☐ Yes ☐ No

Date of Injury:_____ Insurance Co. handling this claim:_____ Claim #_____

Name of Attorney / Adjustor:_____ Tel. # (_____) _____

I certify that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist or any other member of his/her staff responsible for any errors or omissions that I have made in the completion of this form.

Signature of Patient: X _____ **Reviewed by: X** _____ **Date: X** _____

(Parent or Guradian if minor)