

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 _____

(Parent or Guradian if minor)

Date: X _____

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 examination. 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 _____

(Parent or Guradian if minor)

Date: X _____

Health History

To our patients: Although the dentists and/or hygienists 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 alcohol 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?							

