

Welcome!

Thank you for selecting the Hillcrest Dental team! We will strive to provide you with the best possible dental care. To help us meet all of your dental healthcare needs, please fill out this form completely in ink. Please ask us if you have any questions or need assistance – we will be happy to help.

PERSONAL INFORMATION

Name _____
 male female minor single married
 divorced widowed separated
Wishes to be called _____ Birthdate _____
Address _____
City/State _____
School _____ Student Status _____
SS# _____
Employer _____
Employer Address _____
Occupation _____
Referred by _____
Home Phone _____ Cell Phone _____
Work Phone _____ Ext. _____
Where do you prefer to receive calls? Home Work Car
In the event of an emergency, who should we contact? _____
Name _____ Relationship _____
Work # _____ Home # _____

RESPONSIBLE PARTY

Name _____
Birthdate _____ SS# _____
Relationship to patient _____
Address _____
City/State/Zip _____
Employer _____
Employer Address _____
Work Phone _____ Home Phone _____

AUTHORIZATION & RELEASE

I authorize the dentist to release any information including the diagnosis and the record of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or other health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. I understand my credit information may be obtained.

I consent to a diagnostic examination, to include x-rays if deemed important by the doctor, or to treatment, if diagnosed.

X

Signature of patient/guardian or parent/guardian if minor

Date

DENTAL INSURANCE INFORMATION

Name of Insured _____
Relationship of patient _____
Insured birthdate _____ SS# _____
Employer _____ Date employed _____
Employer Address _____
Insurance Company _____
Group# _____
ADDITIONAL INSURANCE: _____
Name of Insured _____
Relationship of patient _____
Insured birthdate _____ SS# _____
Employer _____ Date employed _____
Employer Address _____
Insurance Company _____
Group# _____

FINANCIAL ARRANGEMENTS

For your convenience, we offer the following methods of payment. Please check the option which you prefer.

Payment in full at each appointment

- Cash Personal check
 Credit card Visa MC Discover
 I wish to discuss the dental office's policy.

Late charges: If I do not pay the entire new balance within 90 days of the monthly billing date, a late charge of 1.5% on the balance then unpaid and owed will be assessed each month. I realize that failure to keep this account current may result in you being unable to provide additional services. In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding account balances.

PATIENT NAME _____

BIRTHDATE _____

Dental History

Please Circle

- Yes No Do you have a specific dental problem? Describe _____
Name of previous dentist (optional): _____
Yes No Do you have dental examinations on a routine basis? Last visit _____
Yes No Do you brush and floss on a routine basis? (Twice/day) _____
Yes No Do your gums ever bleed? _____
Yes No Do you like your smile? _____
Yes No Does food catch between your teeth? _____
Yes No Do you want to keep your remaining teeth? _____
Yes No Do you ever have clicking, popping or discomfort in the jaw joint? _____
Yes No Do you brux or grind your teeth? _____
Yes No Have your past experiences in a dental office generally been positive? _____
Yes No Do you smoke or chew tobacco? _____
Yes No Do you get cold sores or fever blisters in your mouth? Describe _____
Yes No Are your teeth sensitive to: [] temperature [] sweet things or [] biting pressure _____
Yes No Have you ever had (please circle) teeth pulled gum surgery orthodontics root canal? _____
Yes No Do you wish to talk to the dentist prior to a dental appt? _____

Medical History

Please Circle

- Yes No Are you under a physician's care now? Name _____ City _____
Yes No Have you ever been hospitalized or had a major operation? Discuss _____
Yes No Have you ever had a serious injury to your head or neck? Discuss _____
Yes No Do you need to take medication prior to a dental appt? _____

Are you allergic to any medications or substances? Please check box below

- [] Aspirin [] Penicillin [] Codeine [] Acrylic [] Metal [] Latex Rubber [] Dental Anesthetic [] Other [] None

Women (Please check): [] Pregnant/Trying to get pregnant [] Breast Feeding [] Taking oral contraceptives

DO YOU NOW HAVE, OR HAVE YOU EVER HAD, ANY OF THE FOLLOWING? PLEASE CHECK APPROPRIATE BOXES.

- Yes No Yes No Yes No Yes No Yes No
[] [] Heart Trouble/Disease [] [] Anemia [] [] Emphysema [] [] Kidney Problems [] [] Herpes
[] [] Heart Murmur [] [] Hemophilia (Bleeding Problems) [] [] Tuberculosis [] [] Renal Dialysis [] [] Stroke
[] [] Angina/Chest Pain [] [] Leukemia [] [] Cancer [] [] Thyroid Disease [] [] Convulsions/Seizures
[] [] Mitral Valve Prolapse [] [] Blood Transfusion [] [] Radiation Therapy [] [] Arthritis/Gout [] [] Hives or Rash
[] [] Scarlet Fever [] [] Lung Disease [] [] Chemotherapy [] [] Cortisone/Steroid [] [] Fainting or Dizziness
[] [] Rheumatic Fever [] [] Breathing Problems/Asthma [] [] Stomach/Intestinal Disease [] [] Pain in Jaw Joints [] [] Glaucoma
[] [] Artificial Heart Valve [] [] Shortness of Breath [] [] Ulcers [] [] Tumor or Growths [] [] Recreational Drug Use
[] [] Heart Pace Maker [] [] Recent Weight Loss [] [] Artificial Joints [] [] Psychiatric Care [] [] Hepatitis A (infections)
[] [] Low Blood Pressure [] [] Taken Phen Phen [] [] Diabetes [] [] Sexually Transmitted [] [] Hepatitis B or C
[] [] High Blood Pressure [] [] Hay Fever [] [] Liver Disease [] [] Diseases [] [] HIV Positive
[] [] Frequent Cough [] [] Sinus Trouble

- Yes No Are you taking any medications, pills or drugs? What _____
Yes No Have you ever had any other serious illness not checked above? Discuss _____

To the best of my knowledge, all the preceding answers are correct. If I have any changes in my health status or if my medicines change, I shall inform the dentist and staff at the next appointment without fail.

X _____ Date _____
PATIENT SIGNATURE (PARENT OR GUARDIAN)

Reviewed by Doctor _____ Date _____ BP _____

History Review and Significant Findings _____

