HILL VIEW DENTAL

Cosmetic Dentistry Implant dentistry Family Dentistry Orthodontics Endodontics

PATIENT INFORMATION

Patient Name_____
Address_____
City_____ State_____ Zip_____
E-Mail Address_____
Employer Name_____
Employer Address_____
Who may we thank for referring you to us for care?
_____

Home Phone_____
Cell Phone_____
Date of Birth_____ Sex M F
Social Security#_____
Marital Status Married Single Child Other
Business Phone_____
Where would you like to be contacted _____

Spouse Name_____
Spouse Employer_____
Employer Address_____
City_____ State_____ Zip_____

Date of Birth_____
Social Security#_____
Spouse Cell Phone_____
Business Phone_____

Name and phone number of emergency contact not living with you _____

If the child is a minor, please list the name of their legal guardian_____
Home Phone_____ CellPhone_____ Work Phone_____
Mailing Address_____ City_____ State_____ Zip Code_____

INSURANCE INFORMATION

Do you have Dental Insurance? Yes_____ No_____
Name of Policy Holder_____
Subscriber ID_____
Insurance Company_____
Address_____

Policy Holders Date of Birth_____
Group Number_____
Group Name_____
Insurance Phone Number_____

I hereby authorize assignment of my insurance rights and benefits to go directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company.

Our policy requires payment in full for all services rendered at the time of each visit. If account is not paid within 90 days of the service date and no financial arrangements have been made, a finance charge at a periodic rate of 1.5% per month will be added to your account. You will be responsible for interest charges as well as legal and collection agency fees that incur during the collection process.

We reserve the right to charge a $100 missed appointment fee. This fee is not covered under your insurance and will be your responsibility. In order to avoid this charge, any necessary cancellations must be made at least 48 hours in advance.

Thank you for your understanding our policies. Please let us know if you have any questions or concerns.

_____

Patient (Guardian) Signature Date

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MEDICAL HISTORY UPDATE

Your Name_____ Birth Date_____
Address_____ Phone #_____
Are you currently under the care of a physician?_____ Yes ____ No _____
Have you been hospitalized during the past two years? Why_____ Yes ____ No _____
Are you taking any medications? Please List: Yes_____ No_____
Are you taking any illegal drugs? Please List:

Please list any allergies to drugs, medications, anesthetics or latex_____

Please tell us if you have or have had any of the following by checking the appropriate box:

□ Bacterial Endocarditis	□ Hemophilia	□ Irregular Heart Beat	□ Diabetes
□ Heart Murmur	□ Blood Disease	□ High Blood Pressure	□ Low Blood Pressure
□ Rheumatic Heart Fever	□ Rheumatic Heart Disease	□ Artificial Heart Valves	□ Congenital Heart Lesion
□ Heart Attack_____year	□ Angina/Chest Pain	□ Heart Surgery_____year	□ Heart Pacemaker_____year
□ Congestive Heart Failure	□ Stomach Problems/Reflux	□ Sickle Cell Anemia	□ Anemia/Blood Problems
□ Excessive Bleeding	□ Asthma	□ Respiratory Disease	□ Shortness of Breath
□ Hay Fever	□ Sinus Problems	□ Tuberculosis	□ Eye Disorders/Glaucoma
□ AIDS/HIV	□ Rheumatism/Arthritis	□ Neurological Problems	□ Epilepsy/Seizures
□ Psychiatric Problems	□ Emotional Problems	□ Alcoholism	□ Chemical Dependency
□ Drug Addiction	□ Tobacco Use	□ Malignancies	□ Cancers, Tumors, Growths
□ Radiation Treatments	□ Kidney Problems	□ Dialysis	□ Liver Problems
□ Hepatitis	□ Stroke	□ Chrons	□ Thyroid Problems
□ Ulcer/Colitis	□ Venereal Disease	□ Herpes	□ Fever Blisters
□ Latex Allergy	□ Pregnant___ months	□ Celiac	□ Oral Contraceptives
□ Immunosuppressive Disorders/ARC		□ Any Artificial Replacement	
□ Other _____		Knee, Hip, Joint, Pins, Plate_____year	

Have you ever taken medication for osteoporosis or to improve bone density? YES_____NO_____
Please list medication_____

DENTAL HISTORY

Previous Dentist Name_____ Phone#_____
How long since your last dental visit?_____ What was done at that time?_____
Have you made regular dental visits? Yes_____ No _____ Have your wisdom teeth been removed? Yes _____ No _____
Were dental x-rays taken recently? _____ Does food get caught in your teeth? Yes _____ No _____
Do you have a current pano or full mouth series? _____ Do you clench or grind your teeth? Yes _____ No _____
Does your jaw click or pop? Yes _____ No _____ Have you lost any teeth or have any teeth been removed?_____
Do your gums bleed or hurt? Yes _____ No _____ How often do you brush your teeth? _____
Do you use dental floss? Yes_____No _____ Do you feel your breath is offensive at times? Yes ____No _____
Have you had any orthodontic work? Yes _____ No _____ Have you ever had gum surgery? Yes _____ No _____
Are you unhappy with the appearance of your teeth? Yes_____No_____Why_____
Do you have frequent head aches, neck aches or shoulder aches? Yes _____ No _____
Are any of your teeth sensitive to hot, cold, sweets, and or pressure? Yes _____ No _____
Have you ever had any problems or complications with previous dental treatment? Yes _____ No _____
Have you experienced any pain or soreness in the muscles of your face or around your ear? Yes _____ No _____

Patient (Guardian) Signature Date