



Patient Information & Dental History

Today's Date _____

Last Name _____ First Name _____ MI _____ Date of Birth _____ Age _____

Sex M or F Soc. Sec. # _____ Please Circle One: Single Married Separated Widow

Mailing Address _____ City _____ State _____ Zip Code _____

Email _____ Home Phone (_____) _____ Cell Phone (_____) _____

Driver's License # _____ Employer _____

WorkPhone (_____) _____ Occupation _____

Are you a full time student? Yes or No If patient is a minor: Mother's DOB _____ Father's DOB _____

Name of Parent _____ Parent Soc. Sec. # _____

Parent Employer _____ Parent Phone (_____) _____

Person Responsible for Account _____ Relationship _____

Emergency Contact _____ Relationship _____ Phone # (_____) _____

If you are filling this form out on behalf of another person, what is your relationship to that person?

Name _____ Relationship _____

Reason for today's visit? _____

How did you hear about us?

In-home Mailer Social Media Insurance Practice Website Internet Family/Friend/Coworker

Other _____ Who can we thank for your visit? _____

Dental Insurance Information (Primary Carrier)

Dental Insurance Information Secondary Coverage

Insured's Name _____ Insured's Name _____

Insured's Employer _____ Insured's Employer _____

Insured's DOB _____ Insured's DOB _____

Insurance Co _____ Insurance Co _____

Insurance Co Address _____ Insurance Co Address _____

Insurance Phone # _____ Insurance Phone # _____

Group # _____ Local # _____ Group # _____ Local # _____

Dental History

On a scale of 1-10, with 10 being the highest rating:

How important is your dental health to you? 1 2 3 4 5 6 7 8 9 10

Where would you rate your current dental health? 1 2 3 4 5 6 7 8 9 10

Where do you want your dental health to be? 1 2 3 4 5 6 7 8 9 10

What would you like to change about your smile?

Color Bite Chipped Teeth Spaces Crowding Smile Makeover Missing Teeth Whiter Teeth

Please share the following dates:

Your last cleaning ____/____/____ Your last oral cancer screening ____/____/____ Your last complete X-rays ____/____/____

What is the most important thing to you about your future smile and dental health? _____

What is the most important thing to you about your dental visit today? _____

Why did you leave your previous dentist? _____

Name of your previous dentist _____

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Although dental personnel primarily treat the area in and around your mouth, your mouth is a 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 dentistry you will receive. Thank you for answering the following questions.

- Are you under a physician's care now? Yes No If yes, please explain _____
- Have you ever been hospitalized or had a major operation? Yes No If yes, please explain _____
- Have you ever had a serious head or neck injury? Yes No If yes, please explain _____
- Are you taking any medications, pills or drugs? Yes No If yes, please explain _____
- Do you take, or have you taken, Phen-Fen or Redux? Yes No If yes, what? _____
- Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Yes No If yes, what? _____
- Are you on a special diet? Yes No If yes, what? _____
- Do you use tobacco? Yes No If yes, what? _____
- Do you use controlled substances? Yes No If yes, what? _____

Are you a woman who is... Pregnant/Trying to get pregnant Nursing Taking oral contraceptives

Are you allergic to any of the following?

- Aspirin Penicillin Codeine Acrylic Other _____
- Metal Latex Sulfa Drugs Local Anesthetics No Known Allergies

Do you have, or have you had any of the following?

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> AIDS/HIV Positive | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis B or C | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Alzheimer's Disease | <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Herpes | <input type="checkbox"/> Rheumatism |
| <input type="checkbox"/> Anaphylaxis | <input type="checkbox"/> Easily Winded | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Emphysema | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Hives or Rash | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Arthritis/Gout | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Excessive Thirst | <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Spina Bifida |
| <input type="checkbox"/> Artificial Joint | <input type="checkbox"/> Fainting Spells/Dizziness | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Stomach/Intestinal Disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Frequent Cough | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Frequent Diarrhea | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Swelling of Limbs |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Breathing Problems | <input type="checkbox"/> Genital Herpes | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Tumors or Growths |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Heart Attack/Failure | <input type="checkbox"/> Pain in Jaw Joints | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Parathyroid Disease | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Cold Sores/Fever Blisters | <input type="checkbox"/> Heart Pacemaker | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Yellow Jaundice |
| <input type="checkbox"/> Congenital Heart Disorder | <input type="checkbox"/> Heart Trouble/Disease | <input type="checkbox"/> Radiation Treatments | |
| <input type="checkbox"/> Convulsions | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Recent Weight Loss | |
| <input type="checkbox"/> Cortisone Medicine | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Renal Dialysis | |

Have you ever had any serious illness not listed above? Yes No If yes, _____

Comments _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian _____

Date _____



Financial Policy

Patient Name (print) _____

Thank you for choosing our office as your dental healthcare provider. We are committed to providing you with the **highest quality** lifetime dental care, so that you may attain optimum oral health. The following is a statement of our financial policy, which we require that you read, agree to, and sign prior to any treatment. Payment is due at the time service is provided. Our office accepts cash, personal checks, credit cards and outside patient financing.

Please check if you would like more information about financing options.

Please Note: Returned checks will be subject to additional fees. In the case it becomes necessary for our office to enlist a collection service and/or legal assistance; you will be responsible for any collection and/or legal charges up to 35%.

Do You Have Insurance?

- We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and your insurance company.
- As a courtesy to you we will help you process all your insurance claims. Please understand that we will provide an insurance estimate to you, however, it is not a guarantee that your insurance will pay exactly as estimated. Your insurance company and your plan benefits will determine the amount paid. We will, of course, do all we can to make sure your estimate is as accurate as possible. If your insurance company has not made payment within 60 days, we will ask that you contact your insurance company to make sure payment is expected. If payment is not received or your claim is denied, you will be responsible for paying the full amount at that time.
- We ask that you sign this form and/or any other necessary documents that may be required by your insurance company. This form instructs your insurance company to make payment directly to our office.
- We ask that you pay the deductible and co-payment, which is the estimated amount, not covered by your insurance company, by cash, check, credit card or Patient Financing at the time we provide the service to you.
- We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. Our office will not, however, enter into a dispute with your insurance company over any claim.

APPOINTMENT CHANGES/CANCELLATIONS/NO-SHOWS

When you schedule an appointment at Hillsboro Village Dental we reserve that time specifically for you. Our goal is to do our very best to respect your time as our patient and we ask that you do the same for us. If for any reason you need to change or reschedule your appointment, we ask you to let us know as soon as possible but with at least 48 HOURS NOTICE. We understand situations arise and this cannot always be fulfilled. After the first late notice, schedule change, or no-show to an appointment, we reserve the right to charge an appointment fee of \$50.00 for any future missed appointments or late notice changes.

We thank you for the opportunity to serve your dental health care needs and welcome any question you may have concerning your care or our financial policy.

Consent:

I have read, understand and agree to the above terms and conditions. I authorize my insurance company to pay my dental benefits directly to my dental office. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a finance, rebilling, collection charge and/or attorney fee will be added to any overdue balance. By signing below, you are authorizing us to call you at any number you provide including calls to mobile/cellular or similar devices for any lawful purpose. You agree to any fees or charges that you may incur for an incoming call from us, and/or outgoing calls to us, to or from any such number, without reimbursement from us.

Patient Signature (Parent if child)

Date



Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name (print) _____

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

**** You may refuse to sign this acknowledgement****

I, _____, have received a copy of this office's Notice of Privacy Practices.

Patient Name (Printed)

Signature

Date

Authorization To Release Information

Purpose: This form is used to obtain authorization to release information regarding yourself covered under the Privacy Act to people other than yourself.

I, _____, authorize the following person(s) to have access to information covered under the Privacy Practice regarding myself.

Name (Printed)

Relationship

Name (Printed)

Relationship

Name (Printed)

Relationship

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

Individual refused to sign

- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (*Please Specify*)
