HILLTOP DENTAL

Hilltop Dental Associates, P.C.

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New Patient Form

Patient Information

Patient Name:_____ Date:_____
Last First MI Preferred

Gender: _____ Family Status: _____

Social Secruity #: _____ Birth Date: _____

Phone (Home):_____ (Work): _____ Ext: _____ Best Time to Call:_____

Address:_____
Street Apartment #

_____
City State Zip Code

Health Information

Date of Last Dental Visit: _____ Reason for this Visit:_____

Have you ever had any of the following? Please check those that apply:

Yes/No
☐☐ AIDS or HIV
☐☐ Allergies _____
_____
☐☐ Anemia
☐☐ Arthritis
☐☐ Artificial Joints _____
☐☐ Asthma
☐☐ Blood Disease
☐☐ Cancer
☐☐ Diabetes
☐☐ Dizziness
☐☐ Epilepsy
☐☐ Excessive Bleeding
☐☐ Fainting

Yes/No
☐☐ Glaucoma
☐☐ Growths
☐☐ Hay Fever
☐☐ Head Injuries
☐☐ Heart Disease
☐☐ Heart Murmur
☐☐ Hepatitis
☐☐ High Blood Pressure
☐☐ Jaundice
☐☐ Kidney Disease
☐☐ Liver Disease
☐☐ Mental Disorders
☐☐ Nervous Disorders
☐☐ Pacemaker

Yes/No
☐☐ Pregnancy, Due Date: _____
☐☐ Radiation Treatment
☐☐ Respiratory Problems
☐☐ Rheumatic Fever
☐☐ Rheumatism
☐☐ Sinus Problems
☐☐ Stomach Problems
☐☐ Stroke
☐☐ Tuberculosis
☐☐ Tumors
☐☐ Ulcers
☐☐ Venereal Disease
other: _____

- Check any of the following that you are currently taking or have taken:
  ☐ Cortisone Drugs ☐ Steroids ☐ Anticoagulants ☐ Blood Thinners ☐ Tranquilizers ☐ Sedatives
- Are you allergic to or do you suffer ill effects from any of the following?:
  ☐ Penicillin ☐ Aspirin ☐ Codeine ☐ Household Bleach ☐ Dental Anesthesia ☐ Other: _____
- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you ever been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: _____Name of Physician:_____
- Are you currently taking or previously taken a bisphosphonate drug? ☐ Yes ☐ No
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: _____

Women Only

- Are you pregnant? ☐ Yes ☐ No
  If yes: How many months? _____ Are you breastfeeding? _____
- Are you presently taking medication of any kind routinely? (Birth control pills, shots or implant, hormone therapy, etc.) Explain: _____

Referral Information

Whom may we thank for referring you to our office?

The above information is true to the best of my knowledge.

Name: _____ Date: _____

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: _____ ☐ Male ☐ Female

☐ Married ☐ Single ☐ Child ☐ Other: _____ Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Employment Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Insurance Information

Primary

Name of insured: _____ Is insured a patient ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID#:_____ Group #:_____

Insured's Address: _____
Street Apartment #

_____
City State Zip Code

Insured's Employer's Name: _____

Employers's Address: _____
Street Apartment #

_____
City State Zip Code

Insurance Plan Name: _____

Secondary

Name of insured: _____ Is insured a patient ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID#:_____ Group #:_____

Insured's Address: _____
Street Apartment #

_____
City State Zip Code

Insured's Employer's Name: _____

Employers's Address: _____
Street Apartment #

_____
City State Zip Code

Insurance Plan Name: _____

Consent of Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1 ½ % per month(18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

Signature of patient, parent or guardian: _____ Date: _____ Relationship to Patient: _____

Signature of patient, parent or guardian: _____ Date: _____ Relationship to Patient: _____