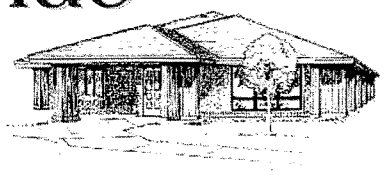
Hill Avenue Dental



Generations of healthy, beautiful smiles

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

Patient Information (Confidential)

Name _____ Preferred to be Called _____ Birthdate _____

Address _____ City, State, Zip _____

Email _____ Home Phone _____ Cell Phone _____

SS# _____ Drivers License # _____

Check Appropriate Box: ❒ Minor ❒ Single ❒ Married ❒ Divorced ❒ Widowed ❒ Separated

If Student, Name of School/College _____ City, State, Zip _____ ❒ Full time ❒ Part time

Patient or parent/Guardian's Employer _____ Work Phone _____

Business Address _____ City, State, Zip _____

Spouse or Parent/Guardian's Name _____ Employer _____ Work Phone _____

Whom may we thank for referring you? _____

Person to Contact in Case of Emergency _____ Phone _____

Responsible Party (If different than above)

Name _____ Relationship to Patient _____

Address _____ City, State, Zip _____

Home Phone _____ Cell Phone _____

Email _____ Birthdate _____

Employer _____ Work Phone _____ SS# _____

Is this person currently a patient in our office? ❒ Yes ❒ No

For you convenience, we offer the following methods of payment. Please check the option you prefer. Payment due in full at each appointment.

❒ Cash ❒ Check ❒ Health Savings Card ❒ Visa ❒ MasterCard ❒ Discover ❒ Care Credit

Insurance Information

Name of Insured _____ Relationship to Patient _____

Birthdate _____ SS# _____ Date Employed _____

Name of Employer _____ Union or Local # _____ Work Phone _____

Address of Employer _____ City, State, Zip _____

Insurance Company _____ Group # _____ Policy/ID# _____

Insurance Co. Address _____ City, State, Zip _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ❒ Yes ❒ No **If yes, complete the following:**

Name of Insured _____ Relationship to Patient _____

Birthdate _____ SS# _____ Date Employed _____

Name of Employer _____ Union or Local # _____ Work Phone _____

Address of Employer _____ City, State, Zip _____

Insurance Company _____ Group # _____ Policy/ID# _____

Insurance Co. Address _____ City, State, Zip _____

— Over Please —

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, _____

Have you ever been hospitalized or had a major operation? ❒ Yes ❒ No If yes, _____

Have you ever had a serious head or neck injury? ❒ Yes ❒ No If yes, _____

Are you taking any medications, pills, or drugs? (We suggest bringing a list.) ❒ Yes ❒ No If yes, _____

Do you take, or have you taken, Phen-Fen or Redux? ❒ Yes ❒ No If yes, _____

Do you take, or have you taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ❒ Yes ❒ No If yes, _____

Are you on a special diet? ❒ Yes ❒ No

Do you use tobacco? ❒ Yes ❒ No

Women: Are you... ❒ Pregnant/Trying to get pregnant? ❒ Nursing? ❒ Taking oral contraceptives?

Are you allergic to any of the following? ❒ Aspirin ❒ Penicillin ❒ Codeine ❒ Acrylic ❒ Metal ❒ Latex ❒ Sulfa Drugs ❒ Local Anesthetics

Other? ❒ Yes ❒ No If yes, _____

Do you use controlled substances? ❒ Yes ❒ No If yes, _____

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

AIDS/HIV Positive	❒ Yes	❒ No	Cortisone Medicine	❒ Yes	❒ No	Hemophilia	❒ Yes	❒ No	Radiation Treatments	❒ Yes	❒ No
Alzheimer's Disease	❒ Yes	❒ No	Diabetes	❒ Yes	❒ No	Hepatitis A	❒ Yes	❒ No	Recent Weight Loss	❒ Yes	❒ No
Anaphylaxis	❒ Yes	❒ No	Drug Addiction	❒ Yes	❒ No	Hepatitis B or C	❒ Yes	❒ No	Renal Dialysis	❒ Yes	❒ No
Anemia	❒ Yes	❒ No	Easily Winded	❒ Yes	❒ No	Herpes	❒ Yes	❒ No	Rheumatic Fever	❒ Yes	❒ No
Angina	❒ Yes	❒ No	Emphysema	❒ Yes	❒ No	High Blood Pressure	❒ Yes	❒ No	Rheumatism	❒ Yes	❒ No
Arthritis/Gout	❒ Yes	❒ No	Epilepsy or Seizures	❒ Yes	❒ No	High Cholesterol	❒ Yes	❒ No	Scarlet Fever	❒ Yes	❒ No
Artificial Heart Valve	❒ Yes	❒ No	Excessive Bleeding	❒ Yes	❒ No	Hives or Rash	❒ Yes	❒ No	Shingles	❒ Yes	❒ No
Artificial Joint	❒ Yes	❒ No	Excessive Thirst	❒ Yes	❒ No	Hypoglycemia	❒ Yes	❒ No	Sickle Cell Disease	❒ Yes	❒ No
Asthma	❒ Yes	❒ No	Fainting Spells/Dizziness	❒ Yes	❒ No	Irregular Heartbeat	❒ Yes	❒ No	Sinus Trouble	❒ Yes	❒ No
Blood Disease	❒ Yes	❒ No	Frequent Cough	❒ Yes	❒ No	Kidney Problems	❒ Yes	❒ No	Spina Bifida	❒ Yes	❒ No
Blood Transfusion	❒ Yes	❒ No	Frequent Diarrhea	❒ Yes	❒ No	Leukemia	❒ Yes	❒ No	Stomach/Intestinal Disease	❒ Yes	❒ No
Breathing Problems	❒ Yes	❒ No	Frequent Headaches	❒ Yes	❒ No	Liver Disease	❒ Yes	❒ No	Stroke	❒ Yes	❒ No
Bruise Easily	❒ Yes	❒ No	Genital Herpes	❒ Yes	❒ No	Low Blood Pressure	❒ Yes	❒ No	Swelling of the Limbs	❒ Yes	❒ No
Cancer	❒ Yes	❒ No	Glaucoma	❒ Yes	❒ No	Lung Disease	❒ Yes	❒ No	Thyroid Disease	❒ Yes	❒ No
Chemotherapy	❒ Yes	❒ No	Hay Fever	❒ Yes	❒ No	Mitral Valve Prolapse	❒ Yes	❒ No	Tonsillitis	❒ Yes	❒ No
Chest Pains	❒ Yes	❒ No	Heart Attack/Failure	❒ Yes	❒ No	Osteoporosis	❒ Yes	❒ No	Tuberculosis	❒ Yes	❒ No
Cold Sores/Fever Blisters	❒ Yes	❒ No	Heart Murmur	❒ Yes	❒ No	Pain in Jaw Joints	❒ Yes	❒ No	Tumors or Growths	❒ Yes	❒ No
Congenital Heart Disorder	❒ Yes	❒ No	Heart Pacemaker	❒ Yes	❒ No	Parathyroid Disease	❒ Yes	❒ No	Ulcers	❒ Yes	❒ No
Convulsions	❒ Yes	❒ No	Heart Trouble/Disease	❒ Yes	❒ No	Psychiatric Care	❒ Yes	❒ No	Venereal Disease	❒ Yes	❒ No
									Yellow Jaundice	❒ Yes	❒ No

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

Consent

1. The undersigned hereby authorizes doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of the patient's dental needs.
2. I also authorize doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment in connection with (patient) _____ . I understand that using anesthetic embodies a certain risk. Furthermore, I authorize and consent that doctor choose and employ such assistance as deemed fit to provide recommended treatment.
3. Lastly, I understand that all 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 other arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that a 1-1/2% finance charge (18% APR) may be added to my account.

Patient _____ Date _____

Parent or Responsible Party _____ Relationship to Patient _____