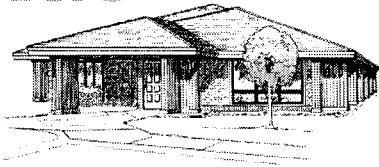


Hill Avenue Dental



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 _____ Birthdate _____ Home Phone _____
Address _____ City, State, Zip _____
Email _____ Cell Phone _____ SS# _____
Check Appropriate Box: Minor Single Married Divorced Widowed Separated
If Student, Name of School/College _____ City, State, Zip _____ Full time Part time
Parent 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 of Insured _____ 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 your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.
 Cash Check Health Savings Card Visa MasterCard Discover Care Credit Citi HC

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 _____
How much is your deductible? _____ How much have you used? _____ Max. Annual Benefit _____

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 _____
How much is your deductible? _____ How much have you used? _____ Max. Annual Benefit _____

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? Yes No If yes, _____
(We suggest bringing a list.)

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