Adult

WELCOME

HILTON FAMILY DENTISTRY

1 About You

Today's Date: ____/____/____ File #: _____

Patient Name: _____
LAST FIRST MI

What You Prefer To Be Called: _____ ❑Male ❑Female

Birthdate: ____/____/____ Age: _____ SS#: _____

Mailing Address: _____

_____
CITY STATE ZIP

Home Phone #: ( ) _____

Work Phone #: ( ) _____ EXT. _____

Cell Phone #: ( ) _____

E-mail Address: _____

Referred By: _____

Employer: _____ How Long? _____

Employer's Address: _____

_____
CITY STATE ZIP

Occupation: _____

Status: ❑ Minor ❑Single ❑Married ❑Divorced ❑Separated ❑Widowed

Spouse's Name: _____

Do you have children: ❑Yes ❑No How many? _____

2 Insurance Info

Primary Dental Insurance

Co. Name: _____

Address: _____

_____
CITY STATE ZIP

Phone #: ( ) _____

Insured's ID#: _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____

Relation: _____ Date of Birth: ____/____/____

Insured's Employer: _____

Secondary Dental Insurance

Co. Name: _____

Address: _____

_____
CITY STATE ZIP

Phone #: ( ) _____

Insured's ID#: _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____

Relation: _____ Date of Birth: ____/____/____

Insured's Employer: _____

3 Account Info

Person ultimately responsible for account

Name: _____

Relation: _____

Billing Address: _____

CITY _____ STATE _____ ZIP _____

SS #: _____

Drivers License #: _____

Work Phone #: ( ) _____

Payment method: ❑Cash ❑Check

_____ /____

❑Credit Card - Enter card # above (if accepted)

_____ Initials I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).

4 In Event of Emergency

Whom should we contact? _____

Relation: _____

Home Phone #: ( ) _____

Work Phone #: ( ) _____ EXT. _____

Cell Phone #: ( ) _____

Who is your Medical Doctor? _____

Medical Doctor's Phone #: ( ) _____

Please continue on back

5 Dental Information

Reason for today's visit: ❑Exam ❑Emergency ❑Consultation Are you in pain: ❑No ❑Yes How Long? _____

Please indicate ☑ any of the following problems:

❑Discomfort, clicking or popping in jaw ❑Lost/Broken Filling(s) ❑Stained Teeth
❑Red, swollen or bleeding gums ❑Teeth Grinding ❑Locking Jaw
❑Sensitive tooth, teeth or gums ❑Ringing in Ears ❑Bad Breath
❑Blisters/Sores in or around the mouth ❑Broken/Chipped Tooth
❑Other: _____

Do you require pre-medication? ❑Yes ❑No ❑Don't Know

Previous Dentist: _____ ( ) _____
Name Phone #

Last Dental exam: ___/___/___ Last Dental X-rays: ___/___/___

Times a day you brush: _____Times a week you floss?____ What type of tooth brush bristles do you use: ❑Soft ❑Medium ❑Hard

How would you rate your smile? (Worst) 1 2 3 4 5 6 7 8 9 10 (Best)

6 Medical History

What medications are you taking? ❑Nerve pills ❑Pain killers (including aspirin) ❑Muscle relaxers
❑Stimulants ❑Blood Thinners ❑Tranquilizers ❑Insulin ❑Meds for Osteoporosis
❑Other(s), please list: _____

Have you ever taken: Bisphosponates (ex. Aredia/Fosamax) ❑Yes ❑ No Phen-fen/Redux ❑Yes ❑No

Do you have or have you had any of the following diseases, medical conditions or procedures?

Y N AIDS/HIV Positive	Y N Stroke	Y N Easily Winded	Y N Osteoporosis	Y N Shingles
Y N Alzheimer's Disease	Y N Cancer	Y N Emphysema	Y N Pain in Jaw Joints	Y N Fainting Spells/Dizziness
Y N Anaphylaxis	Y N Chemotherapy	Y N High Cholesterol	Y N Ulcers	Y N Frequent Cough
Y N Anemia	Y N Heart Attack/Failure	Y N Hives or Rash	Y N Venereal Disease	Y N Frequent Headaches
Y N Angina	Y N Heart Murmur	Y N Asthma	Y N Hemophilia	Y N Low Blood Pressure
Y N Epilepsy or Seizures	Y N Heart Pacemaker	Y N Blood Disease	Y N Hepatitis A	Y N Lung Disease
Y N Excessive Bleeding	Y N Psychiatric Care	Y N Stomach/Intestinal Disease	Y N Hepatitis B or C	Y N Mitral Valve Prolapse
Y N Hypoglycemia	Y N Cortisone Medicine	Y N Bruise Easily	Y N Herpes	Y N Tuberculosis
Y N Sinus Trouble	Y N Diabetes	Y N Glaucoma	Y N High Blood Pressure	Y N Tumors or Growths
Y N Leukemia	Y N Drug Addiction	Y N Hay Fever	Y N Scarlet Fever	Y N Convulsions

Please list any other surgeries or medical conditions you have or ever had:

_____

Are you allergic to any of the following? ❑Latex ❑Penicillin / Amoxicillin ❑Tetracycline ❑Aspirin
❑Dental Anesthetics ❑Foods: ❑Others:

Do you use toboacco: ❑No ❑Yes/How used: _____ How much? _____ How long? _____

Please rate your general health from 1-10: _____ Do you wear contact lenses: ❑Yes ❑No

For women: Are you taking Birth Control pills: ❑Yes ❑ No How many children have you had?

Are you pregnant: ❑ No ❑Yes/How long: _____ Are you nursing: ❑Yes ❑ No

UPDATE
OFFICE USE

- We invite you to discuss with us any questions regarding our services. The best Dental health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interst charges and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my reponsibility to inform this office of any changes to the information I have provided.

_____ **I acknowledge that I have received a copy of the Summary of Privacy Notice.**
Initials

Signature _____ Date ___/___/___
❑Adult Patient ❑ Parent or Guardian ❑Spouse

_____ / /
Initials Date
Comments
_____ / /
Initials Date
Comments
_____ / /
Initials Date
Comments