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 #: _____

Cell Phone #: ( ) _____

Payment method: ❑Cash ❑Check ❑Credit Card

_____ 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).
Initials

4 In Event of Emergency

Whom should we contact? _____

Relation: _____

Home Phone #: ( ) _____

Cell Phone #: ( ) _____

Who is your Medical Doctor? _____

Medical Doctor's Phone #: ( ) _____

Pharmacy Preference: _____

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 Chest Pains	Y N Frequent Headaches	Y N Hives or Rash	Y N Recent Weight Loss
Y N Alzheimer's Disease	Y N Cold Sores/Fever Blisters	Y N Glaucoma	Y N Hypoglycemia	Y N Renal Dialysis
Y N Anaphylaxis	Y N Congenital Heart Disorder	Y N Hay Fever	Y N Irregular Heartbeat	Y N Rheumatic Fever
Y N Anemia	Y N Convulsions	Y N Heart Attack/Failure	Y N Kidney Problems	Y N Scarlet Fever
Y N Angina	Y N Cortisone Medicine	Y N Heart Murmur	Y N Leukemia	Y N Shingles
Y N Arthritis/Gout	Y N Diabetes	Y N Heart Pacemaker	Y N Liver Disease	Y N Sinus Trouble
Y N Artificial Heart Valve	Y N Drug Addiction	Y N Heart Trouble/Disease	Y N Low Blood Pressure	Y N Stomach/Intestinal Disease
Y N Artificial Joint	Y N Easily Winded	Y N Hemophilia	Y N Lung Disease	Y N Stroke
Y N Asthma	Y N Emphysema	Y N Hepatitis A	Y N Mitral Valve Prolapse	Y N Swelling of Limbs
Y N Blood Disease	Y N Epilepsy or Seizures	Y N Hepatitis B or C	Y N Osteoporosis	Y N Thyroid Disease
Y N Bruise Easily	Y N Excessive Bleeding	Y N Herpes	Y N Pain In Jaw Joints	Y N Tuberculosis
Y N Cancer	Y N Fainting Spells/Dizziness	Y N High Blood Pressure	Y N Psychiatric Care	Y N Tumors or Growths
Y N Chemotherapy	Y N Frequent Cough	Y N High Cholesterol	Y N Radiation Treatments	Y N Ulcers
				Y N Venereal Disease

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

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
___/___/___
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Comments
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Comments