Account Information:

Self ☐ M ☐ F

Name:_____

Marital Status: M S Div.

Preferred Name:_____
(If different than above)

Date of Birth:_____ SS#:_____

Address:_____

City:_____State:_____Zip:_____

Phone: (C)_____ (H)_____
(W)_____

E-Mail:_____

Occupation:_____

Employer:_____

Dental Ins. Co. _____

Relationship to Dental Insurance Subscriber:
☐ Self ☐ Spouse ☐ Child ☐ Other

Spouse (if applicable)

Name:_____

Preferred Name:_____
(If different than above)

Date of Birth:_____ SS#:_____

Address:_____

City:_____State:_____Zip:_____

Phone: (C)_____ (H)_____
(W)_____

E-Mail:_____

Occupation:_____

Employer:_____

Dental Ins. Co. _____

Relationship to Dental Insurance Subscriber:
☐ Self ☐ Spouse

☐ Please advise the business office of additional coverage.

I, the undersigned, certify that I (or my dependents) have dental insurance coverage and that I adding directly to the dentist all insurance benefits for services rendered, otherwise payable to me. ***I understand that I am financially responsible for all charges, whether or not paid by insurance companies.*** *I hereby authorize the release of all information necessary to secure the payment of benefits. I authorize the use of this signature in all insurance submissions.*

_____ _____
Signature Date

I ***(patient and or****/patient's guardian) understand that the information given today is correct to the best of my knowledge. It is also my understanding that this information will be held in the strictest confidence and that it is my responsibility to inform this office of* ***any*** *changes in my medical or dental status.*

_____ _____ _____
Signature Date Dr.'s Initials

Medical/Dental History

It is important that we know about your medical and dental history. These facts have a direct bearing on the treatment provided in this office. Information is held in strict confidence.

Are you APPREHENSIVE about dental treatment?	Y	N
Have you ever had Periodontal (GUM) treatment?	Y	N
Have you ever had ORTHODONTIC (braces) treatment?	Y	N
Do your gums BLEED, feel TENDER, or IRRITATED?	Y	N
Are your teeth SENSITIVE to hot, cold, sweets or pressure?	Y	N
Are you aware of GRINDING or CLENCHING your teeth?	Y	N
Do you have HEADACHES, EARACHES OR NECK PAINS?	Y	N

Are you unhappy with the APPEARANCE of your teeth? Would you like your smile to look BETTER or DIFFERENT?

Explain _____

Why have you come to the dentist today? _____

Are you currently in pain? Please explain. _____

Previous dentist: _____
Name Address Phone

Last Dental Visit _____
Date Purpose

Who referred you to our office? _____

Have you had any of the following problems or diseases? Please Circle.

Heart disease/attack	Kidney disease/trouble	Epilepsy/seizures	Asthma/sinus problems
Heart Surgery	Attention Deficit ADD	Anemia	**Allergies**/specify
Heart Murmur	Liver disease	Psychiatric treatment	_____
Rheumatic Fever	Hepatitis A/B/C	Cancer	_____
Mitral Valve Prolapse	Blood transfusion	Chemotherapy/radiation	_____
Artificial Heart Valve	Hemophilia	STD/HPV	**Current Medications**
Heart Pacemaker	AIDS/HIV	Diabetes	_____
High Blood Pressure	Substance abuse/addiction	Thyroid Disease	_____
Stroke	Ulcers	Cold sores/fever blisters	_____
Artificial joints	Tuberculosis		_____

Are you allergic or had any negative reactions to the following? Circle.
Local Anesthetics Penicillin Erythromycin Tetracycline Nitrous Oxide Codeine Others_____

Do you have any other serious medical conditions? Please explain.

Physician's Name: _____

Are you currently under his/her care?	Y	N
For women: Are you pregnant?	Y	N

Revised 02-04-14

OUR FINANCIAL POLICIES AND YOUR DENTAL INSURANCE

We are committed to providing you with the best possible care. If you have dental insurance, we want to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and understanding of our financial policies. Please be sure to read this form in its entirety and sign at the bottom.

We encourage our patients to be familiar with the cost of their dental treatment. A fee **estimate** is available to you before you consent to treatment. If you would like an **estimate**, please be sure to request one.

- Your insurance is a contract between you, your employer and the insurance company. We are not a third party to that contract. As a service to you, we will help you file your insurance claim for reimbursement, providing we have complete and current insurance information. However, we consider the patient responsible for the account.

- Not all services are a covered benefit in all contracts. The insurance coverage purchased by your employer selects certain services they will not cover. You are responsible for deductibles and non-covered services. Please pay **estimated** portion as services are rendered. The remaining balance should there be any, is due within 20 days after receipt of our billing statement.

- We offer financial arrangements for extensive work such as crowns, bridges, and dentures. All arrangements that extend beyond 60 days shall be in writing.

- It is important to note that in order to save money, some less expensive plans allow a benefit only for the least expensive method of treatment and will bundle or downcode procedures, leaving you to pay the additional amount. For example, a low cost basic plan may allow only for silver fillings as opposed to white composite fillings. We, at Hilliard Dental Associates, no longer place amalgam fillings because of the health risks of mercury exposure and aesthetic advantage of white fillings.

- Some insurance companies claim that they have paid the usual and customary amount for a dental procedure. ALL of our fees fall in the reasonable, usual, and customary range. Please feel free to compare our fee to the real area norm by visiting *www.fairhealthconsumer.org*

- If you have any questions concerning our financial policies or any uncertainty regarding insurance coverage, **PLEASE** do not hesitate to ask. If you receive a bill that you question, promptly call the office so that we can explain or correct the situation. We are here to help you.

- *A note to divorced parents:* The parent who brings the patient to our office will be responsible for our professional fees unless specific alternate arrangements are made in advance.

- To avoid a broken appointment fee, we kindly ask for 48 hours' notice for all cancellations.

I have read and agree to the Financial Policy stated above that applies to me.

_____ _____

Signature (Patient/Responsible Party) **Date**

Revised 05/15/13

PATIENT CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- **Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)**
- **Obtaining payment from third party payers (e.g. my insurance company)**
- **The day-to-day healthcare operations of your practice**

I have also been informed of and given the right to review and secure a copy of your *Notice of Privacy Practices*,which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this____ day of _____, 20___.

Print Patient Name: _____

Relationship to Patient: _____

Signature: _____

Practice Name: Hilliard Dental Associates

Address 4621 Leap Ct.

City/State/Zip Hilliard, OH 43026