Hill Family Dentistry

We are pleased to welcome you to our office. Please take a few minutes to fill out this form as completely as you can. If you have any questions we'll be glad to help you.

PERSONAL & CONTACT INFORMATION

Name _____
Last First MI (Preferred)

Birthdate _____ SS# _____

Gender: { } M { } F Married: { } Yes { } No Child: { } Yes { } No

Email (for appointment reminders) _____

How did you hear about us? _____

(If someone referred you here, please write down their name so we can thank them.)

ADDRESS

Address _____ APT # _____

City _____ State _____ Zip _____

Mobile Phone _____ Home Phone _____ Other _____

HEALTH INFORMATION

Reason for today's visit: _____ Date of last visit: _____

Have you ever had any of the following? Please circle those that apply:

AIDS	Excessive Bleeding	Kidney Disease	Stomach Problems
Allergies	Fainting	Liver Disease	Stroke
Anemia	Glaucoma	Mental Disorder	Tuberculosis
Arthritis	Growths	Nervous Disorder	Tumors
Artificial Joints	Hay Fever	Pacemaker	Ulcers
Asthma	Head Injuries	Currently Pregnant/Nursing	Venereal Disease
Blood Disease	Heart Disease	Due Date: _____	Codeine Allergy
Cancer	Heart Murmur	Radiation Treatment	Latex Allergy
Diabetes	Hepatitis	Respiratory Problems	Penicillin Allergy
Dizziness	High Blood Pressure	Rheumatic Fever	Sulfa Allergy
Epilepsy	Jaundice Sinus Problems		Other: _____

Have you ever had any complications following dental treatment? _____ If yes, explain:

_____

Have you been admitted to a hospital or needed emergency care during the past two years? _____If yes, explain:

_____

Are you now under the care of a physician? _____ Name: _____

Do you have any health problems that need further clarification? _____ If yes, explain:

_____

Please list current medications or provide a list: _____

SIGNATURE

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform Hill Family Dentistry at the next appointment.

_____ Date: _____

Signature of Patient, Parent or Guardian

Hill Family Dentistry

Head of House Hold/Guarantor of Payment

Name: _____ DOB: _____ SS#: _____

Address: _____ State: _____ Zip: _____

Phone: _____ Email: _____

Dental Benefits

Hill Family Dentistry has contacted your benefit carrier and obtained the best information possible based on the information provided. I understand that estimates are based off the insurance information that was provided. I understand that Hill Family Dentistry staff has attempted to acquire the most accurate estimates possible, but that the carrier will determine what they will pay based on plan provisions. I understand the estimates provided are not a guarantee of coverage. I agree to be financially responsible for any treatment that is completed from a treatment plan. Hill Family Dentistry processes carrier claims as a courtesy I understand that it is my responsibility to understand my dental benefits and exclusions.

Termination of Benefits

I will not hold Hill Family Dentistry or any of its associates financially responsible if treatment is completed with expired dental benefits I understand those fees will become a patient responsibility.

Downgraded Fillings

Dental benefits may be downgraded to silver amalgam fillings. I agree to the increase in cost for white composite fillings.

Downgraded Crowns

Dental benefits may be downgraded to a base metal crown. If I use a ceramic crown, I agree to the difference in cost associated with a ceramic crown.

Collection/Payment Fees

I agree to pay a $25.00 insufficient funds fee if a check or card transaction does not process. I also agree to pay a $25.00 delinquent account fee for any balance that ages over 35 days without any payment on the account. I will be liable for any collection or attorney fees for services rendered to me or those for whom I am responsible for. I am also aware of the cancellation/no show policy.

Health History/Emergency Treatment

I have disclosed my health history, including allergies, reactions to medicine, diseases and past procedures. I understand that withholding information may affect the outcome of the procedure(s) or courses(s) of treatment. I have given a list of all medications currently prescribed by the staff.

Consent for Treatment

I authorize the provider, Dr. Timothy Hill and any other qualified hygienists, assistants and staff to perform the treatment(s) listed on my treatment plans. I give consent to be treated for x-rays and examinations, prophylaxis and perio maintenance treatment if required. If further treatment is needed, I understand that I can accept that treatment at my discretion.

I authorize any necessary life-saving procedures to be performed in the event of an emergency during procedure(s). I understand that a blood transfusion may be a part of a life-saving procedure and give my consent for necessary blood work. I give my consent for the administration of any medication that may be required as a life-saving measure.

I understand the risks inherent in treatment(s) rendered. I have discussed these risks with the dentist. The dentist has/will addressed my questions and concerns I have presented. I understand the expected results of the procedure(s). I understand these results cannot be guaranteed and may not be achieved. I am aware of my right to waive treatment of any kind. I am aware of the possible consequences of non-treatment.

Signature: _____ Date: _____

Hill Family Dentistry

ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
(Please Print Name)

_____
(Signature)

_____
(Date)

We attempted to obtain written Acknowledgement of Receipt of Notice of Privacy Practices, but acknowledgement could not be obtained because:

Individual refused to sign

Communications barriers prohibited obtaining the acknowledgement

An emergency situation prevented us from obtaining acknowledgement

Other (Please Specify)

_____

_____

_____
Employee Name

_____
Office Name

_____
Employee Signature

_____
Date

Cancellation Policy and Fees

24 hour cancellation notice is required on all appointments. If a cancellation is necessary, please call our office at 480.588.8127 and/or send an email to office@hillfamilydentistry.com.

Cancellation fees may be applied to accounts if notice is received less than **24 hours** in advance. The following fees may be assessed:

- **$25.00 for appointments 1-2 hours in length**
- **$50.00 for appointments 2 or more hours in length**

We understand that emergencies occur. Cancelled or missed appointments that are rescheduled within 30 days will have the fee waived. After 30 days, the fee will be collected at the next visit. Patients that are unable to give notice of cancellations 3 or more times (per family), will be required to place a $25 hold fee to schedule appointments. The hold fee will then be applied toward patient responsibility fees.

We are happy to serve our patients. Thank you for helping us provide outstanding treatment to all of our patients.

-Hill Family Dentistry

Print Name: _____

Signature: _____ Date: _____

*Signed Cancellation Policy applies to the family file