Hillside Dental Associates

PATIENT INFORMATION

DATE

PATIENT'S NAME | BIRTHDATE | AGE

ADDRESS | CITY, ZIP

SEX ☐M ☐F

PATIENT'S EMPLOYER | WORK PHONE

HOME PHONE | CELL PHONE

EMAIL ADDRESS

PERSON TO CONTACT IN CASE OF EMERGENCY

ADDRESS | PHONE

RELATIONSHIP TO PATIENT

REFERRED BY | MAY WE CONTACT YOU VIA EMAIL OR TEXT REGARDING YOUR APPOINTMENTS? ☐ YES ☐ NO

RESPONSIBLE PARTY INFORMATION

RESPONSIBLE PARTY'S NAME | BIRTHDATE

RESIDENCE ADDRESS | CITY, ZIP

HOME PHONE | SSN

EMPLOYER | EMPLOYER PHONE

EMPLOYER ADDRESS | CITY, ZIP

WILL DENTAL INSURANCE BE INVOLVED? ☐Yes ☐No | IF YES, PLEASE COMPLETE NEXT SECTION

INSURANCE INFORMATION

PRIMARY INSURANCE

SUBSCRIBER'S NAME | INSURED ID NO.

SUBSCRIBER'S RELATIONSHIP TO PATIENT | BIRTHDATE

NAME OF INSURANCE COMPANY

GROUP NO. | ADDRESS

SUBSCRIBER'S EMPLOYER | EMPLOYER'S PHONE NO.

SECONDARY INSURANCE

SUBSCRIBER'S NAME | INSURED ID NO.

SUBSCRIBER'S RELATIONSHIP TO PATIENT | BIRTHDATE

NAME OF INSURANCE COMPANY

GROUP NO. | ADDRESS

SUBSCRIBER'S EMPLOYER | EMPLOYER'S PHONE NO.

Hillside Dental Associates

Patient's Health History

Name _____ Birthdate _____

Has another dentist treated you in the past? Name _____ Phone _____

Medical doctor's name _____

Describe your general health _____

Have you had or do you have any serious illness? _____ Past surgery _____

Undergone general anethesia? _____ When? _____

Are you presently under a doctor's care? _____ For what? _____

Are you presently taking any medications, including birth control? _____

List medications and why you are taking them _____

_____

_____

Patient's Health History

Anemia or Bleeding Disorder . . . . . ☐ Yes ☐ No

Diabetes . . . . . ☐ Yes ☐ No

High or Low Blood Pressure . . . . . ☐ Yes ☐ No

Heart Disease . . . . . ☐ Yes ☐ No

Do you have any allergies or adverse reactions to medication or drugs? . . . . . ☐ Yes ☐ No

Asthma, Tuberculosis, Breathing Problems . . . . . ☐ Yes ☐ No

Cancer . . . . . ☐ Yes ☐ No

Hepatitis or HIV (AIDS) positive . . . . . ☐ Yes ☐ No

Artificial Joints . . . . . ☐ Yes ☐ No

Have you been instructed by your Physician to premedicate with an antibodic prior to dental treatment? . . . . . ☐ Yes ☐ NO

Taken any medication for Osteoporosis? . . . . . ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No

Do you have any other medical conditions that are not listed above? _____

Do you know of any other information that might affect your dental treatment? _____

Health Questionaire Acknowledgement and Consent to Proceed: I certify that the answers to the health questions are accurate and correct to the best of my knowledge. Since a change of medical condition or medications can affect dental treatment, I understand the importance of and agree to notify the dentist at any subsequent appointment.

I authorize the dentists of Hillside Dental and/or such associates or assistants as s/he may designate to perform those procedures as may be deemed necessary or advisable to maintain my dental health or the dental health of any minor or other individual for which I have responsibility, including arrangement and/or administration of any sedative (including nitrous oxide), analgesic, therapeutic, and/or other pharmaceutical agent(s), including those related to restorative, palliative, therapeutic or surgical treatment.

I understand that the administration of local anesthetic may cause an untoward reaction or side effects, which may include, but are not limited to brusing; hematoma; cardiac stimulation; muscle soreness; and temporary or rarely, permanent numbness. I understand that occasionally needles break and may require surgical retrieval. Occasionally drops of local anesthetic may contact the eyes and facial tissues and cause temporary irritation.

I understand that as part of dental treatment, including prevenive procedures such as cleanings and basic dentistry including fillings of all types, teeth may remain sensitive or even possibly quite painful both during and after completion of treatment. Dental materials and medications may trigger allergic or sensitivity reactions. After lengthy appointments, jaw muscles may also be sore or tender. Holding one's mouth open can, in a predisposed patient, precipitate a TMJ disorder. Gums and surrounding tissues may also be sensitive or painful during and/or after treatment. Although rare, it is also possible for the tongue, cheek or other oral tissues to be inadvertently abraded or lacerated (cut) during routine dental procedures. In some cases sutures or additional treatment may be required.

I understand that as part of dental treatment items including, but not limited to crowns, small dental instruments, drill components, etc. may be aspirated (inhaled into the respiratory system) or swallowed. This unusual situation may require a series of x-rays to be taken by a physician or hospital and may, in rare cases, require bronchoscopy or other procedures to ensure safe removal.

I understand the need to disclose to the dentist any prescription drugs that are currently being taken or that have been taken in the past. I understand that taking the class of drugs prescribed for the prevention of osteoporosis, such as Fosamax, Boniva or Actonel, may result in complications of non-healing of the jawbones following oral surgery or tooth extraction.

I do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any, which may be associated with general preventive and operative treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit or the benefit of my minor child or ward. I acknowledge that the nature and purpose of the foregoing procedures have been explained to me if necessary and I have been given the opportunity to aks questions.

Signed _____ Date _____ Relationship _____

OFFICE USE ONLY

_____ RMH _____ Date _____

_____ RMH _____ Date _____

_____ RMH _____ Date _____

_____ RMH _____ Date _____

_____ RMH _____ Date _____