Hildebrand Dental

Patient Information:

Patient Name: _____ Preferred Name: _____
Last Name First M.I.

□Male □Female Marital Status: □Single □Married □Other Date of Birth: _____/_____/_____ SSN: _____/_____/_____

Home Address: _____
Street City State Zip Code

Email Address: _____

Preferred Contact Number: (_____)_____ Work Number: (_____)_____ Cell Number: (_____)_____

Employer Name: _____ Employer Address: _____
Street City State Zip Code

Emergency Contact:

Name: _____ Relation: _____ Phone: (_____)_____

How did you hear about us? ☐ Google ☐ Website ☐ Facebook ☐ Insurance ☐ Other ☐ Friend/Family Member

Who can we thank for referring you? _____

Dental History:

Reason for your visit today? _____ Date of last Dental visit? _____

How often do you floss? _____ How often do you brush? _____

Interested in straightening your teeth? □Yes □No Interested in whitening your teeth? □Yes □No

Please check "YES" or "NO" if you have/had:

Yes	No		Yes	No	
□	□	Allergic reaction to local anesthetics	□	□	Dry mouth
□	□	Bad breath	□	□	Food collection between teeth
□	□	Bad previous dental experience	□	□	Growths or sore spots in your mouth
□	□	Blisters/Canker sores/Cold sores	□	□	Gum Disease/Periodontal Disease
□	□	Botox/Dermal fillers	□	□	Gums swollen, tender or bleeding
□	□	Burning sensation on tongue	□	□	Loose teeth or broken fillings
□	□	Cheek or lip biting	□	□	Mouth breathing/snoring
□	□	Chewing/smoking tobacco	□	□	Nitrous oxide
□	□	Clench or grind teeth	□	□	Orthodontic treatment
□	□	Clicking/popping, TMJ/jaw, or head/neck pain	□	□	Sensitivity to pressure or irritants (cold/heat/sweets)

Medical History:

Are you under a physician's care? Yes□ No□ If yes, please explain_____ Physician's name:_____

Have you ever had any serious illnesses or operation? Yes□ No□ If yes, please describe_____

List any allergies (medications): _____ Allergy to latex? Yes□ No□

List any medications or history not listed: _____

_____

Please check "YES" or "NO" if you have/had:

Yes	No		Yes	No	
□	□	Artificial joints	□	□	Allergies, hay fever, sinus trouble
□	□	Arthritis	□	□	Asthma: Date of last episode ___/___/____
□	□	Cancer	□	□	Emphysema / COPD
□	□	Chemotherapy	□	□	Respiratory disease
□	□	Radiation treatment	□	□	Sleep apnea: Do you use CPAP? ____
□	□	Acid reflux	□	□	Anemia
□	□	AIDS / HIV	□	□	Artificial heart valves / Pacemaker
□	□	Cortisone treatments	□	□	Bleeding abnormally with operations/surgery
□	□	Diabetes: type ____	□	□	Blood disease, clotting disorders
□	□	Epilepsy	□	□	Blood transfusion: Approximate date ___/___/____
□	□	Fainting: When does it occur _____	□	□	Circulatory problems
□	□	Glaucoma	□	□	Heart attack: Approximate date ___/___/____
□	□	Headaches: How often _____	□	□	Heart murmur
□	□	Hepatitis (type) ____	□	□	High blood pressure: Last reading date ___/___/____
□	□	Immune deficiencies	□	□	Low blood pressure
□	□	Jaundice	□	□	Shortness of breath
□	□	Kidney disease	□	□	Stroke: Approximate date ___/___/____
□	□	Thyroid problems: type ____	□	□	Swelling of feet/ankles
□	□	Tuberculosis	□	□	Weight loss/gain
			□	□	Pregnant (females) Due Date: _____

Hildebrand Dental

General Consent Form:

By initialing below, I give consent –

_____ for treatment by Hildebrand Dental. I am responsible for payment of all services on my behalf or my dependents. I authorize and request my insurance company (if applicable) to pay directly to Hildebrand Dental. I understand that if my dental insurance should happen to send payment to me, directly, that it is my responsibility to forward the payment to Hildebrand Dental. I understand that my dental insurance may pay less than the actual bill for services. I further understand that quotes from Hildebrand Dental are only estimates, not a guarantee of coverage and my insurance may pay more or less.

_____ for Hildebrand Dental to use photographs, radiographs and/or study models for educational or promotional purposes.

_____ for Hildebrand Dental to leave Protected Health Information on my answering machine/ voicemail.

_____ to the use and disclosure of your Protected Health Information by Hildebrand Dental, our team, and our business associates for treatment, payment and health care operations. For a more detailed description of uses and disclosures for these purposes, please review our Notice of Privacy Practices.

_____ I understand that a $25 fee will be assessed for any missed appointments or cancellations with less than 24 hour notice.

You have the right to review our Notice of Privacy Practices prior to signing this consent. You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting: Hildebrand Dental at (816) 873-3260 or by email at hildebranddental@gmail.com or by mail at 110 Hospital Dr. Smithville, MO 64089.

You have the right to request that we restrict our uses or disclosures of your Protected Health Information which we are otherwise permitted to make for treatment, payment and health care operations, understanding that we are not required to agree to these restrictions. However, if we agree to such restrictions, they are binding on us. Finally, you may refuse to consent to the uses or disclosure of your Protected Health Information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Protected Health Information. I understand that I may obtain a copy of the Notice of Privacy Practices and revisions upon my request.

By signing this, I acknowledge that I have reviewed and answered the questions on this form to the best of my knowledge and understanding, and agree to the content of the information listed above.

Patient/Guardian signature_____ Date: ____/____/_____

Reviewed by: _____