FORT HILL
family dentistry

Welcome to our office! Please tell us about yourself.

Name: _____
last *first* *MI* *title*

Preferred Name: _____ ☐ Male ☐ Female

Address: _____ City: _____ State: _____ ZIP: _____

Date of Birth: _____ Social Security # _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Domestic Partner

Home Phone: _____ Work Phone: _____

Cell Phone: _____ E-mail Address: _____

I prefer to be contacted on my: home phone work phone cell phone e-mail *(please circle one)*

Employer: _____

Whom may we thank for referring you or how did you hear about our office? _____

_____

Person to contact in case of emergency: _____ Phone: _____

Insurance – Primary

Subscriber Name: _____ Relationship to Patient: _____ Subscriber DOB: _____

Subscriber SSN/ID: _____ Subscriber Employer: _____

Insurance Company Name: _____

Insurance Company Address: _____

Insurance Company Phone: _____ Group Number: _____

Insurance – Secondary

Subscriber Name: _____ Relationship to Patient: _____ Subscriber DOB: _____

Subscriber SSN/ID: _____ Subscriber Employer: _____

Insurance Company Name: _____

Insurance Company Address: _____

Insurance Company Phone: _____ Group Number: _____

Initials: _____ DOB: _____

Medical History

Do you have a personal physician? ☐ Yes ☐ No

Physician's Name: _____ Physician's Phone: _____

Date of last visit: _____

Your current physical health is: ☐ Good ☐ Fair ☐ Poor

Are you currently under the care of a physician? ☐ Yes ☐ No

Please explain: _____

Do you require antibiotics before dental treatment? ☐ Yes ☐ No

Do you use tobacco in any form? ☐ Yes ☐ No

Are you currently taking drugs, medications, over-the-counter medicines (including aspirin), natural remedies? ☐ Yes ☐ No

Please list each one: _____

Yes	No	Conditions
☐	☐	Abnormal Bleeding
☐	☐	Alcohol Abuse
☐	☐	Allergies
☐	☐	Anemia
☐	☐	Arthritis
☐	☐	Artificial Heart Valve
☐	☐	Asthma
☐	☐	Blood Transfusion
☐	☐	Cancer
☐	☐	Chemotherapy
☐	☐	Chest Pain
☐	☐	Colitis
☐	☐	Congenital Heart Defect
☐	☐	Diabetes
☐	☐	Difficulty Breathing
☐	☐	Drug Abuse
☐	☐	Emphysema
☐	☐	Epilepsy
☐	☐	Facial Surgery
☐	☐	Fainting Spells
☐	☐	Fever Blisters
☐	☐	Frequent Headaches

Yes	No	Conditions
☐	☐	Glaucoma
☐	☐	HIV+ AIDS
☐	☐	Heart Attack
☐	☐	Heart Murmur
☐	☐	Heart Surgery
☐	☐	Hemophilia
☐	☐	Hepatitis A
☐	☐	Hepatitis B
☐	☐	Hepatitis C
☐	☐	High Blood Pressure
☐	☐	Joint Replacement
☐	☐	Kidney Problems
☐	☐	Liver Disease
☐	☐	Low Blood Pressure
☐	☐	Osteoporosis
☐	☐	Pace Maker
☐	☐	Psychiatric Problems
☐	☐	Radiation Therapy
☐	☐	Rheumatic Fever
☐	☐	Seizures
☐	☐	Sexually Transmitted Disease
☐	☐	Shingles

Yes	No	Conditions
☐	☐	Sickle Cell Disease
☐	☐	Sinus Problems
☐	☐	Stroke
☐	☐	Thyroid Problems
☐	☐	Tuberculosis
☐	☐	Ulcers

Yes	No	Allergies
☐	☐	Aspirin
☐	☐	Codeine
☐	☐	Dental Anesthetics
☐	☐	Erythromycin
☐	☐	Jewelry
☐	☐	Latex
☐	☐	Metals
☐	☐	Penicillin
☐	☐	Tetracycline

Yes	No	If Female, please answer:
☐	☐	Are you taking Birth Control Pills?
☐	☐	Are you pregnant? If so, # of weeks _____
☐	☐	Are you nursing?

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my personal or medical information.

Signature: _____ Date: _____

Dental History

How may we help you today? _____

Your current dental health is: ☐ Good ☐ Fair ☐ Poor

Are you currently in pain? ☐ Yes ☐ No

Do you now or have you had any pain/discomfort in your jaw joint? (TMJ) ☐ Yes ☐ No

Do you like your smile? ☐ Yes ☐ No

Are you happy with the color of your teeth? ☐ Yes ☐ No

Do your gums bleed? ☐ Yes ☐ No

How many times do you: floss/week? _____ brush/day? _____

Are your teeth sensitive to heat, cold or anything else? ☐ Yes ☐ No

Have you ever had a serious/difficult problem with any previous dental work? ☐ Yes ☐ No

Have you ever had any unfavorable dental experiences? ☐ Yes ☐ No

When was your last dental cleaning? _____

When was your last dental visit? _____

Why did you leave your previous dentist? _____

How can we accommodate you better during your dental visit? _____

_____

HIPAA Privacy Practices

The Notice of Privacy Practices covers services provided to you by our office. We are required by law to maintain the privacy of protected health information and to provide you with the Notice of our legal duties and privacy practices with respect to protected health information. Protected health information is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

The full document is available to you if you would like to review it.

I acknowledge I have reviewed Fort Hill Family Dentistry's health information privacy and security policies and procedures.

Signature: _____ Date: _____

Financial Agreement

Dental treatment is an excellent investment in an individual's medical and psychological well-being. Dr. Paap feels very strongly that everyone deserves the highest quality dental care available, and with that in mind, we have several ways to make the treatment you need attainable.

We encourage and appreciate payment in full at the time of service. However, we are sensitive to the fact that in some instances this may not be an option. We offer financing programs to help you get the smile you want.

Payments can be made with most major credit cards, cash and check (under $500). Long-term financing is also available with CareCredit.

We also offer short-term in-office financing (ninety days, with a signed agreement prior to beginning treatment), generous senior citizen discount for individuals over 65 (10%), and discounts on pre-payment of treatment over $500 (7%).

For patients with insurance:

As a convenience to you, our office will bill your insurance (primary & secondary). We will do everything we can to make sure that you receive the maximum benefit from your insurance plan(s).

Please remember that your insurance allotment may not cover all dental costs. Most dental insurance plans are not designed to pay in full for all of your dental expenses, and often will not cover or pay in full for dental care that you need.

It is also important to remember that many decisions made by insurance companies have more to do with profit margins and stock holder dividends, and much less to do with your health. We place a much higher premium upon your health, and will only recommend what is best for our patients.

The insurance relationship constitutes an agreement between the insurance company, the employer, and the patient. It is your responsibility to pay any deductible, co-payment, or any other balance not covered by your insurance plan. If insurance has not paid within 90 days, we will request full payment from you.

We know questions can arise concerning insurance matters. We encourage you to discuss any questions you may have with us. We will do everything possible to answer your questions.

Thank you for the confidence you have placed in us. We are complimented that you have chosen us for your dental care and we genuinely care about you. If you have any questions, please do not hesitate to ask.

Assignment & Release

I understand that I am financially responsible for all charges. I assign insurance benefits to Fort Hill Family Dentistry. I understand insurance payments are property of Fort Hill Family Dentistry. I hereby authorize the doctor to release information necessary to secure the payments of benefits. I authorize the use of this signature on insurance submissions.

Signature: _____ Date: _____