Hilltop Dentists

2019 *******PLEASE COMPLETE ENTIRE FORMS*******

PATIENT'S INFORMATION

Pt. Name (Last, First) Male Female Jr. Sr.	Date of Birth Age Married Single Divorced Widowed
Address	City State Zip
Cell Phone # ( )	Landline Phone # ( )
Preferred Contact Landline Phone ☐ Cell Phone ☐	Who would you like to get "Family" Apt reminders? Name: _____ Phone: ( )
E-mail Address- You will **ONLY** get Appt. Reminders	Social Security # 18 & Older, **YES** we must have your FULL SS# on File!!
If Minor (under 18) Name of Guardian	Guardians Date of Birth & SS# Social Security # _____ Date of Birth

DENTAL INSURANCE INFORMATION

Do You have Dental Insurance? YES ☐ NO ☐		
Employer -For Insurance Purposes	Work Phone # ( )	Extension
Primary Dental Insurance Company:	Insurance ID #	Group #
Secondary Dental Insurance Company:	Insurance ID #	Group #
Medical Insurance (yes, we must have)	Insurance ID #	Group #
Who is the Primary Insurance Policy Holder?	Who is Financially Responsible for Patients Co-pays/Deductibles balance? (NOT INSURANCE)	
Who is the Secondary Insurance Policy Holder?		

SPOUSE'S INFORMATION

Spouse's Name (last, First, MI)	Date of Birth/ Age	
Address ☐ Check here if same as you	City State	Zip
Spouse's Phone# ( ) Is this a Cell Phone? Yes No	Spouse's Social Security #	

RELEASE:

I authorize the dentists to perform diagnostic procedure and treatments as may be necessary for proper dental care.

I authorize release of any information concerning my (or my child's) health care, advise and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

I authorize release of any information concerning my (or my child's) health care, advise and treatment to another dentists.

I authorize release of any responsible for all costs of dental treatment.

I understand that I am responsible for all costs of dental treatments.

I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me.

I attest to the accuracy of the information on this page.

I authorize Hilltop Dentists to bill what they seem deemed necessary to my Medical & Dental Insurance.

Patient/Guardian Signature _____ Today's Date _____