Hilltop Dentists

PATIENT'S INFORMATION

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

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 #
Who is the Primary Insurance Policy Holder?	SS# DOB
Who is the Secondary Insurance Policy Holder?	SS# DOB
Who is financially Responsible for co-pays/balance?	

SPOUSE'S INFORMATION

Spouse's Name (last, First, MI)	Date of Birth Age
Address ☐ Check here if same as patient	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 _____

Hilltop Dentists
Patient History

DENTISTS COMMENTS/CONCERNS

1 Patients Name: _____

1. Reason of Initial Visit _____
2. How Long Since Your Last Dental Visit? _____
3. How Do You Feel About Your Teeth in General? _____
4. Are you happy with the appearance of your teeth? YES ☐ NO ☐
   If NO, Explain _____
5. Have you had any unpleasant dental experiences? YES ☐ NO ☐
   If YES, Explain _____
6. What is your biggest concern? _____
7. Have you had any previous dental work done? If Yes, Explain…

   _____

   _____
8. Do you Clench or grind your teeth? YES ☐ NO ☐
9. Have you ever been hospitalized or had a major operation? YES ☐ NO ☐
10. Are you taking any medication? If Yes, Please list them.

    _____

    _____
11. Do you use any Tobacco Products? If Yes, how many/much per day? _____
12. Do You consume alcoholic beverage? If Yes, How many per day? _____
13. Are you allergic to any of the following? (please circle which ones)
    Aspirin Penicillin Codeine Acrylic Metal Latex Sulfa Local Anesthetics
    Others: _____
14. Do you or have you ever had any of the following? (please circle)
    AIDS/HIV Positive Hepatitis B or C High Cholesterol Excessive Thirst
    Sinus Trouble Frequent Headaches Cancer Cold Sores/Fever Blisters
    Heart Trouble/Disease Diabetes Anemia Artificial Heart Valve Asthma
    Blood Disease Stroke Chemotherapy Heart Murmur Hepatitis A
    High Blood Pressure Excessive Bleeding Fainting Spells/Dizziness
    Blood Transfusion Bruise Easily Mitral Valve Prolapse
    Pain in Jaw Joints Drug Addiction Epilepsy or Seizures Artificial Joint
    Irregular Heartbeat Breathing Problems Low Blood Pressure
    Heart Attack/Failure Pacemaker Chest Pains Kidney Problems
15. Have you ever had any serious illness not listed? If yes, please explain
16. Are you Pregnant? _____

Any Comments:

_____

Patient Signature, or Guardian Date:

Hilltop Dentists

Dr. James Ford & Dr. James Fehrman
12265 N. State Rd
Otisville, MI 48463
PH: (810) 631-4573
FX: (810) 631-9600

PATIENT HIPAA CONSENT FORM

I understand that as part of my healthcare, this organization originates and maintains dental records describing my health history, symptoms, examination, test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication with the many health care professionals who contribute to my care
- A source of information for applying my diagnosis and procedural information to my bill
- A means by which a third-party payer can verify that services billed were actually provided
- A tool for providers and specialist to assess the quality and the competence of the dental care, provided, as well as the detection of any possible future issues

I understand that I have the right to review the notice prior to signing this consent. I understand that the terms of this Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon.

Date: _____

Signature Patient/Guardian _____

Print Patient Name: _____

I GIVE HILLTOP DENTIST PERMISSION TO DISCUSS MY DENTAL RECORDS WITH THE FOLLOWING PERSON

_____

Print Name Date

_____

Relationship to patient

HILLTOP DENTISTS
Dr. James Ford & Dr. James Fehrman
12265 N. State Rd
Otisville, MI 48463

PLEASE READ THE FOLLOWING OFFICE POLICIES AND SIGN AND DATE

I would like to take a few moments to make you aware of some concerns of ours and also your responsibilities on a few topics.

1) ***Appointment Responsibility:*** As a courtesy, we attempt to confirm all next day appointments. Unfortunately, we are not able to contact everyone during office hours. It is strongly felt that keeping an appointment is the **"patients"** responsibility. Therefore, we ask that each patient give **24-hour notice** when any conflict with an appointment arises. If an appointment is not cancelled within 24-hour notice there will be a charge of **$60.00** for Saturday appointments, and weekly appointments there will be a **$40.00** charge.

2) ***Patient Financial Responsibilities:*** The patient (or patient's guardian, if a minor) is ultimately responsible for the payment for her treatment and care. We are pleased to assist you by billing for our contracted insurers. However, the patient is required to provide us with the most correct and updated information about their insurance, and will be responsible for any charges incurred if the information provided is not correct or updated. Patients are responsible for the payment of co-pays, co-insurance, deductibles, and all other procedures or treatment not covered by their insurance plan. Payment is due at the time of service, and for your convenience, we accept cash, check, and most major credit cards at our office. Patients may incur, and are responsible for the payment of additional charges at the discretion of Dr. Ford & Dr. Fehrman. These charges may include (but are not limited to):

   - Charge for returned checks.
   - Charge for broken/missed appointments without 24 hours advance notice
   - Charge for the copying and distribution of patient medical records.

3) ***Co-pays and deductibles:*** As a courtesy, we try our best to verify all Insurance. However, it is the patient's responsibility to know what is or is not covered under their dental plan. It is the full responsibility of the adult patient, the parent of an adult patient that is on the parents account, or the parent of the minor patient, to pay their portion of the dental charges, not covered by the insurance company, at the time of services. Most dental insurance's require co-pay and have deductibles. It is your responsibility as the patient, or parent of the patient to know your insurance policies. The receptionists will assist you to the best of their ability in researching your coverage and costs. However, our office does not set insurance guidelines or co-pays.

Please sign and date the lines below to state that you agree and understand all the contents in this letter.

Name _____ Date _____
Print Name

Name _____ Date _____
Patient's Signature/Guardian if Minor

Name Guardian _____ Date _____