Hilltop Dentists

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

CHILD'S INFORMATION

Patient Name: (Last, First, Middle)	Date of Birth Age Male ☐ Female ☐
Address	City State Zip
Phone # Cell ☐ Landline ☐ ( )	School Name Grade
E-mail Address- you will **ONLY** get Appt. Reminders	Social Security # - Our system requires a SS# on file

PARENT/GUARDIAN INFORMATION

Father's Name (Last, First, Middle)	Father's Social Security #
Father's Employer	Father's Employer's Phone # ( )
Father's Birthdate:	Father's Dental Insurance Primary or Secondary?
Mother's Name (Last, First, Middle)	Mother's Social Security #
Mother's Employer	Mother's Employer's Phone # ( )
Mother's Birthdate:	Mother's Dental Insurance Primary or Secondary?

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 #

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