Hilltop Dental of Auburn

FAMILY DENTISTRY 402.274.3709

WWW.HILLTOPDENTALOFAUBURN.COM

# NEW PATIENT QUESTIONNAIRE

Welcome! How did you hear about us?_____

Where do you work? _____

Hobbies: _____

What is important to you in your relationship with your dentist? _____

_____

Why did you leave your last dentist office? _____

_____

Any dental fears with treatment? _____

Please indicate your preferred pharmacy: _____

If there were one thing you could change about your smile, what would it be?

_____

On a scale of 1–10 (10 = very healthy), how healthy does your mouth feel? _____

# PATIENT REGISTRATION

**Patient Name: _____Preferred Name (if different): _____**

**Address: _____**

**City: _____State: _____Zip:_____**

**Cell #: _____ Home #: _____Work #: _____**

**Birth Date: _____ Social Security #: _____**

**Email: _____**

## Dental Insurance Information

**Policy Holder's Name: _____**

**Birth Date: _____Social Security #: _____**

**Employer: _____**

**Name of Insurance Company: _____ID #: _____**

## Responsible Party (If other than the patient)

**Responsible Party Name: _____**

**Address: _____City: _____State:_____Zip:_____**

**Cell #:_____Home #: _____Work #: _____**

**Relationship to Patient: _____**

# OFFICE & FINANCIAL POLICIES

Thank you for choosing Hilltop Dental of Auburn as your dental provider. Below are our current office and financial policies.

## Canceled Appointments

If you are unable to keep your reserved appointment, please give 24 hours' notice.

## Insurance

Please bring your insurance card to your appointment. You are responsible for deductibles and non-covered services. Estimated patient portions are due at the time of service. After insurance processes your claim, any remaining balance is your responsibility.

## No Insurance

Payment is due at the time of service. If you cannot pay in full, arrangements must be made with the Office Manager.

## Payment Methods

Cash or check: 5% discount for uninsured patients paying in full on the day of service.

Credit cards accepted: Visa, MasterCard, Discover, American Express. A 3% Surcharge will be added to each transaction.

Hilltop Dental of Auburn may update these policies at any time without notice. By signing below, you acknowledge understanding and acceptance of these policies and responsibility for all services rendered.

Patient Name (Print):_____Date: _____

Responsible Party Signature: _____

Relationship to Patient: _____

# ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

A copy of the office privacy practices can be seen upon request at the front desk.

I, (print name)_____, have read, received, or declined a copy of this office's Notice of Privacy Practices.

Signature: _____Date: _____