

Hilltop Dental of Auburn

Welcome! How did you hear about us? _____

Where do you work? _____

Hobbies you enjoy _____

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

Why did you leave your last dentist's office?

Any dental fears?

What is 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 _____

Address _____ City _____ State _____ Zip _____

Cell # _____ Home # _____ Work # _____

Birth Date _____ Soc Sec# _____ Email _____

Dental Insurance Information

Policy Holder's Name _____ Birth Date _____

Soc Sec# _____ Employer _____

Name of Insurance Company _____ ID # _____

Responsible Party

Responsible Party Name (if other than the patient) _____

Address _____ City _____ State _____ Zip _____

Cell # _____ Home # _____ Work # _____

Relationship to Patient _____

Eaglesoft Medical History(Copy)

Patient Name:

Birth Date:

Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, c

Name of your General Physician/Specialist Yes No If yes _____

Have you ever been hospitalized or had a major operation? Yes No If yes _____

Have you ever had a serious head or neck injury? Yes No If yes _____

Are you taking any medications, pills, or drugs? Yes No If yes _____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Yes No If yes _____

Do you use tobacco? Yes No

Do you use controlled substances? Yes No If yes _____

Women: Are you...

Pregnant/Trying to get pregnant? Nursing? Taking oral contraceptives?

Are you allergic to any of the following?

Aspirin Penicillin Codeine Acrylic
 Metal Latex Sulfa Drugs Local Anesthetics

Other? If yes _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive <input type="radio"/> Yes <input type="radio"/> No	Cortisone Medicine <input type="radio"/> Yes <input type="radio"/> No	Hemophilia <input type="radio"/> Yes <input type="radio"/> No	Radiation Treatments <input type="radio"/> Yes <input type="radio"/> No
Alzheimer's Disease <input type="radio"/> Yes <input type="radio"/> No	Diabetes <input type="radio"/> Yes <input type="radio"/> No	Hepatitis A <input type="radio"/> Yes <input type="radio"/> No	Anaphylaxis <input type="radio"/> Yes <input type="radio"/> No
Drug Addiction <input type="radio"/> Yes <input type="radio"/> No	Hepatitis B or C <input type="radio"/> Yes <input type="radio"/> No	Renal Dialysis <input type="radio"/> Yes <input type="radio"/> No	Anemia <input type="radio"/> Yes <input type="radio"/> No
Easily Winded <input type="radio"/> Yes <input type="radio"/> No	Herpes <input type="radio"/> Yes <input type="radio"/> No	Angina <input type="radio"/> Yes <input type="radio"/> No	Emphysema <input type="radio"/> Yes <input type="radio"/> No
High Blood Pressure <input type="radio"/> Yes <input type="radio"/> No	Rheumatism <input type="radio"/> Yes <input type="radio"/> No	Epilepsy or Seizures <input type="radio"/> Yes <input type="radio"/> No	High Cholesterol <input type="radio"/> Yes <input type="radio"/> No
Artificial Heart Valve <input type="radio"/> Yes <input type="radio"/> No	Excessive Bleeding <input type="radio"/> Yes <input type="radio"/> No	Hives or Rash <input type="radio"/> Yes <input type="radio"/> No	Shingles <input type="radio"/> Yes <input type="radio"/> No
Artificial Joint <input type="radio"/> Yes <input type="radio"/> No	Hypoglycemia <input type="radio"/> Yes <input type="radio"/> No	Sickle Cell Disease <input type="radio"/> Yes <input type="radio"/> No	Asthma <input type="radio"/> Yes <input type="radio"/> No
Fainting Spells/Dizziness <input type="radio"/> Yes <input type="radio"/> No	Irregular Heartbeat <input type="radio"/> Yes <input type="radio"/> No	Sinus Trouble <input type="radio"/> Yes <input type="radio"/> No	Frequent Cough <input type="radio"/> Yes <input type="radio"/> No
Kidney Problems <input type="radio"/> Yes <input type="radio"/> No	Blood Transfusion <input type="radio"/> Yes <input type="radio"/> No	Leukemia <input type="radio"/> Yes <input type="radio"/> No	Stomach/Intestinal Disease <input type="radio"/> Yes <input type="radio"/> No
Breathing Problems <input type="radio"/> Yes <input type="radio"/> No	Frequent Headaches <input type="radio"/> Yes <input type="radio"/> No	Liver Disease <input type="radio"/> Yes <input type="radio"/> No	Stroke <input type="radio"/> Yes <input type="radio"/> No
Bruise Easily <input type="radio"/> Yes <input type="radio"/> No	Low Blood Pressure <input type="radio"/> Yes <input type="radio"/> No	Cancer <input type="radio"/> Yes <input type="radio"/> No	Lung Disease <input type="radio"/> Yes <input type="radio"/> No
Thyroid Disease <input type="radio"/> Yes <input type="radio"/> No	Chemotherapy <input type="radio"/> Yes <input type="radio"/> No	Mitral Valve Prolapse <input type="radio"/> Yes <input type="radio"/> No	Tonsillitis <input type="radio"/> Yes <input type="radio"/> No
Chest Pains <input type="radio"/> Yes <input type="radio"/> No	Heart Attack/Failure <input type="radio"/> Yes <input type="radio"/> No	Osteoporosis <input type="radio"/> Yes <input type="radio"/> No	Tuberculosis <input type="radio"/> Yes <input type="radio"/> No
Cold Sores/Fever Blisters <input type="radio"/> Yes <input type="radio"/> No	Heart Murmur <input type="radio"/> Yes <input type="radio"/> No	Pain in Jaw Joints <input type="radio"/> Yes <input type="radio"/> No	Tumors or Growths <input type="radio"/> Yes <input type="radio"/> No
Congenital Heart Disorder <input type="radio"/> Yes <input type="radio"/> No	Heart Pacemaker <input type="radio"/> Yes <input type="radio"/> No	Parathyroid Disease <input type="radio"/> Yes <input type="radio"/> No	Ulcers <input type="radio"/> Yes <input type="radio"/> No
Heart Trouble/Disease <input type="radio"/> Yes <input type="radio"/> No			

Have you ever had any serious illness not listed above? Yes No If yes _____

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X _____ Date: _____

Hilltop Dental of Auburn

Office and Financial Policies

At our practice, we are committed to providing high-quality dental care while maintaining clear communication with our patients. The following policies help ensure efficient scheduling, accurate diagnosis, and financial transparency.

Radiographic (X-Ray) Policy

To properly diagnose and monitor your oral health, we follow a routine preventative radiographic schedule for all patients, regardless of insurance coverage:

- Front-of-the-mouth X-rays (Periapicals) are taken once per year.
- Side-of-the-mouth X-rays (Bitewings) are taken once per year.
- A panoramic X-ray is taken once every 3–5 years, or as needed based on clinical judgment.

Appointment Policy

We kindly request at least 24 hours' notice if you need to cancel or reschedule your appointment. This allows us to offer the time to another patient in need of care.

Financial Policy

- Patients are responsible for paying the estimated cost of services at the time of their appointment.
- As a courtesy, we may submit insurance claims on your behalf; however, insurance coverage is not guaranteed.
- Any remaining balance after insurance processing is the sole responsibility of the patient and is due promptly upon notification.

Payment Methods

Cash or Check: There is a 5% discount for uninsured patients paying in full on the day of service.

Credit Cards: There will be a 3% surcharge applied to credit card transactions. Debit cards and health savings account cards will not have a surcharge applied.

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.

Print Name: _____ Date: _____

Signature: _____

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: _____