HILLTOP Dental

General Dentist in Lincoln, NE

NEW PATIENT FORMS

1500 S 70th St, Suite 200 · Lincoln, NE 68506 · (402) 489-7373

Please print, complete and bring these pages to your first visit.

PATIENT INFORMATION

Patient name _____ Birthdate _____

Home address _____

City _____ State _____ ZIP _____

Home phone _____ Cell _____ Work _____

Email address _____

Preferred method of contact ☐ Call ☐ Text ☐ Email Other _____

Employer _____ Social Security # (for insurance) _____

Emergency contact _____ Phone _____

RESPONSIBLE PARTY (if different from patient)

Name _____ Relationship to patient _____

Billing address _____

City _____ State _____ ZIP _____

Birthdate _____ Email _____ Preferred phone _____

INSURANCE

Do you have insurance that we may file for you? ☐ Yes ☐ No

If yes, please bring your insurance card so we can make a copy.

Are you a dependent under age 26? ☐ Yes ☐ No

FINANCIAL AND RECORDS AUTHORIZATION

Thank you for trusting Hilltop Dental with your care. I authorize my insurance company to pay all benefits directly to Hilltop Dental. I understand that insurance may pay less than the actual charges submitted, and I agree to be responsible for payment of all services provided to me or my dependents. I authorize Hilltop Dental to release any and all clinical records and information concerning my care, or my dependent's care, to third parties and/or other health professionals.

_____ _____

Patient (or parent/guardian) signature Date

HEALTH HISTORY

Patient name _____

MEDICAL HISTORY

Name of physician _____ Date of last medical exam _____

Medications you take (prescription, over-the-counter, herbal and supplements) _____

_____

Are you taking blood-thinning medication? ☐ Yes ☐ No For what condition? _____

Are you taking bisphosphonate medication? ☐ Yes ☐ No For what condition? _____

Do you have any artificial joints or other implants? ☐ Yes ☐ No Which? _____

Women: Are you pregnant, or may you be? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Check any of the following conditions you have or have been treated for:

- ☐ Heart trouble
- ☐ Heart murmur
- ☐ Cardiac device
- ☐ Diabetes
- ☐ Rheumatic fever
- ☐ Arthritis
- ☐ Glaucoma
- ☐ Osteoporosis
- ☐ Epilepsy / seizures
- ☐ Cancer or tumor
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Stroke
- ☐ Blood pressure
- ☐ Tuberculosis
- ☐ Substance abuse
- ☐ Tobacco use / vaping
- ☐ Immune disorder
- ☐ Mental health
- ☐ Blood disorder
- ☐ Sinus issues
- ☐ AIDS / HIV / STD

Allergies, or any condition not listed above _____

Are you receiving, or have you had, radiation therapy? ☐ Yes ☐ No For what condition? _____

Are you receiving, or have you had, chemotherapy? ☐ Yes ☐ No For what condition? _____

Do you have a port? ☐ Yes ☐ No

DENTAL HISTORY

What brings you in for dental care at this time? _____

What concerns do you have about your mouth? _____

What, if anything, has kept you from receiving dental care? _____

Are you happy with your smile and front teeth? ☐ Yes ☐ No If not, why? _____

Check any of the following you have or have been treated for:

- ☐ Biting sensitivity
- ☐ Gum disease
- ☐ Headaches / facial pain
- ☐ Snoring / sleep apnea
- ☐ Cold / hot sensitivity
- ☐ Grinding / clenching
- ☐ Orthodontics / braces
- ☐ TMJ problems
- ☐ Nightguard
- ☐ Food catching
- ☐ Bad breath
- ☐ Bone loss
- ☐ Frequent cavities
- ☐ Dental implants

Any other dental concerns _____

The information above is necessary to provide the best care possible. I acknowledge that I have answered all questions accurately and to the best of my knowledge.

_____ _____

Patient (or parent/guardian) signature Date