Welcome

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us - we will be happy to help.

Patient # _____

SS#/SIN _____

Date _____

Patient Information (CONFIDENTIAL)

Name _____ Birthdate _____ Home Phone _____

Address _____ City _____ State/Prov. _____ Zip/P.C. _____

Email _____ Cell Phone _____

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

If Student, Name of School/College _____ City _____ State/Prov. _____ ☐ Full Time ☐ Part Time

Patient or Parent/Guardian's Employer _____ Work Phone _____

Business Address _____ City _____ State/Prov. _____ Zip/P.C. _____

Spouse or Parent/Guardian's Name _____ Employer _____ Work Phone _____

Whom may we thank for referring you? _____

Person to contact in case of emergency _____ Phone _____

Responsible Party

Name of Person Responsible for this Account _____ Relationship to Patient _____

Address _____ Home Phone _____

Email _____ Cell Phone _____

Driver's License# _____ Birthdate _____ Financial Institution _____

Employer _____ Work Phone _____ SS#/SIN _____

Is this person currently a patient in our office? ☐ Yes ☐ No

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.

☐ Cash ☐ Personal Check Credit Card ☐ VISA ☐ MasterCard ☐ I wish to discuss the office's payment policy.

Insurance Information

Name of Insured _____ Relationship to Patient _____

Birthdate _____ SS#/SIN _____ Date Employed _____

Name of Employer _____ Union or Local # _____ Work Phone _____

Address of Employer _____ City _____ State/Prov. _____ Zip/P.C. _____

Insurance Company _____ Group # _____ Policy/ID # _____

Ins. Co. Address _____ City _____ State/Prov. _____ Zip/P.C. _____

How much is your deductible? _____ How much have you used? _____ Max. annual benefit _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ Yes ☐ No IF YES, COMPLETE THE FOLLOWING:

Name of Insured _____ Relationship to Patient _____

Birthdate _____ SS#/SIN _____ Date Employed _____

Name of Employer _____ Union or Local # _____ Work Phone _____

Address of Employer _____ City _____ State/Prov. _____ Zip/P.C. _____

Insurance Company _____ Group # _____ Policy/ID # _____

Ins. Co. Address _____ City _____ State/Prov. _____ Zip/P.C. _____

How much is your deductible? _____ How much have you used? _____ Max. annual benefit _____

Over Please

Hilliard Modern Dental

Modern Dentistry. Comfortable Care.

As part of our on-going efforts to make Hilliard Modern Dental the best office it can be and to better ensure that you receive the outstanding care you deserve please take a moment to fill out this survey.

Prior to your first appointment how did you hear about or gather information about our office? ***Please check all that apply.***

_____ Internet

_____ Google

_____ Yahoo/Bing

_____ Insurance Co. Website

_____ Phonebook or Yellowpages

_____ Family Member, if so who?

_____

_____ Friend, Co-worker, neighbor, if so who?

_____

_____ Newspaper Ad

_____ Mailer/Postcard

_____ Our support of schools, local charities, and community events

_____ Other, please list

_____

Your comfort and trust is vitally important to us. If you've had a past, negative dental experience we'd like to know about it. If you've had an unpleasant experience related to any of the following ***please check all that apply.***

_____ Pain _____ Anxiety _____ Financial/Insurance Disagreement

_____ Perceived disrespect or rudeness by doctor or staff.

_____ Not understanding or feeling like the treatment you received was unnecessary.

_____ Feeling like your wants, needs, and/or expectations were not satisfied.

Would a monthly newsletter benefit your ability to better understand your dental treatment and issues related to dentistry? _____ Yes _____ No

If we develop such a newsletter would you like to receive it via email _____ or mail _____?

What dental issues would you like to know more about? ***Please check all that apply.***

_____ Whitening _____ Veneers _____ Crowns/Bridges _____ Dental Implants

_____ Conscious Sedation Dentistry _____ Oral Appliances for the Treatment of Sleep Apnea

_____ TMJ Disorders _____ Invisalign/Clear Braces _____ The Process of Dental Disease/Pain

_____ Other, please list _____