Hilltop Dentists

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

PATIENT'S INFORMATION

Pt. Name (Last, First) Male Female Jr. Sr.	Date of Birth Age
Preferred/Nick Name:	Married Single Widowed Divorced
Address	City State Zip
Cell Phone # ( )	Landline Phone # ( )
Social Security # 18 & Older, **YES** we must have your FULL SS# on File!!	E-mail Address- You will **ONLY** get Appt. Reminders
Preferred Pharmacy City	Pharmacy Phone Number: ( )

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 #
Who is the Primary Insurance Policy Holder?	SS#	DOB
Who is the Secondary Insurance Policy Holder?	SS#	DOB
Who is financially Responsible for co-pays/balance?		

1) ***Appointment Responsibility:*** As a courtesy, we attempt to confirm all next day appointments. Unfortunately, we are not able to contact everyone during office hours. It is strongly felt that keeping an appointment is the **"patients"** responsibility. Therefore, we ask that each patient give **24-hour notice** when any conflict with an appointment arises. If an appointment is not cancelled within 24-hour notice there will be a charge of **$60.00** for Saturday appointments, and weekly appointments there will be a **$40.00** charge.

2) ***Patient Financial Responsibilities:*** The patient (or patient's guardian, if a minor) is ultimately responsible for the payment for her treatment and care. We are pleased to assist you by billing for our contracted insurers. However, the patient is required to provide us with the most correct and updated information about their insurance, and will be responsible for any charges incurred if the information provided is not correct or updated. Patients are responsible for the payment of co-pays, co-insurance, deductibles, and all other procedures or treatment not covered by their insurance plan. Payment is due at the time of service, and for your convenience, we accept cash, check, and most major credit cards at our office. Patients may incur, and are responsible for the payment of additional charges at the discretion of Dr. Ford & Dr. Fehrman.

3) ***Co-pays and deductibles:*** As a courtesy, we try our best to verify all Insurance. However, it is the patient's responsibility to know what is or is not covered under their dental plan. It is the full responsibility of the adult patient, the parent of an adult patient that is on the parents account, or the parent of the minor patient, to pay their portion of the dental charges, not covered by the insurance company, at the time of services. Most dental insurance's require co-pay and have deductibles. It is your responsibility as the patient, or parent of the patient to know your insurance policies. The receptionists will assist you to the best of their ability in researching your coverage and costs. However, our office does not set insurance guidelines or co-pays. You are also authorizing Hilltop Dentists permission to bill out what we deem necessary to your Medical & Dental Insurance company.

Patient Signature

Today's Date

Hilltop Dentists
Patient History

DENTISTS COMMENTS/CONCERNS

1 Patients Name: _____

1. Reason of Initial Visit _____
2. How Long Since Your Last Dental Visit? _____
3. How Do You Feel About Your Teeth in General? _____
4. Are you happy with the appearance of your teeth? YES ☐ NO ☐
   If NO, Explain _____
5. Have you had any unpleasant dental experiences? YES ☐ NO ☐
   If YES, Explain _____
6. What is your biggest concern? _____
7. Have you had any previous dental work done? If Yes, Explain…

   _____

   _____
8. Do you Clench or grind your teeth? YES ☐ NO ☐
9. Have you ever been hospitalized or had a major operation? YES ☐ NO ☐
10. Are you taking any medication? If Yes, Please list them.

    _____

    _____
11. Do you use any Tobacco Products? If Yes, how many/much per day? _____
12. Do You consume alcoholic beverage? If Yes, How many per day? _____
13. Are you allergic to any of the following? (please circle which ones)
    Aspirin Penicillin Codeine Acrylic Metal Latex Sulfa Local Anesthetics
    Others: _____
14. Do you or have you ever had any of the following? (please circle)
    AIDS/HIV Positive Hepatitis B or C High Cholesterol Excessive Thirst
    Sinus Trouble Frequent Headaches Cancer Cold Sores/Fever Blisters
    Heart Trouble/Disease Diabetes Anemia Artificial Heart Valve Asthma
    Blood Disease Stroke Chemotherapy Heart Murmur Hepatitis A
    High Blood Pressure Excessive Bleeding Fainting Spells/Dizziness
    Blood Transfusion Bruise Easily Mitral Valve Prolapse
    Pain in Jaw Joints Drug Addiction Epilepsy or Seizures Artificial Joint
    Irregular Heartbeat Breathing Problems Low Blood Pressure
    Heart Attack/Failure Pacemaker Chest Pains Kidney Problems
15. Have you ever had any serious illness not listed? If yes, please explain
16. Are you Pregnant? _____

Any Comments:

_____

Patient Signature, or Guardian Date:

Hilltop Dentists
HIPAA Consent

I understand that as part of my healthcare, this organization originates and maintains dental records describing my health history, symptoms, examination, test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication with the many health care professionals who contribute to my care
- A source of information for applying my diagnosis and procedural information to my bill
- A means by which a third-party payer can verify that services billed were actually provided
- A tool for providers and specialist to assess the quality and the competence of the dental care, provided, as well as the detection of any possible future issues

I understand that I have the right to review the notice prior to signing this consent. I understand that the terms of this Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon.

Date: _____

Signature Patient/Guardian _____

Print Patient Name: _____

I GIVE HILLTOP DENTIST PERMISSION TO DISCUSS MY DENTAL RECORDS WITH THE FOLLOWING PERSON

_____

Print Name Date

_____

Relationship to patient

Hilltop Dentists
Office Policies

PLEASE READ THE FOLLOWING OFFICE POLICIES AND SIGN AND DATE

I would like to take a few moments to make you aware of some concerns of ours and your responsibilities on a few topics.

1.) ***Appointment Responsibility:*** As a courtesy, we attempt to confirm all next day appointments. Unfortunately, we are not able to contact everyone during office hours. It is strongly felt that keeping an appointment is the "patients" responsibility. Therefore, we ask that each patient give 24-hour notice when any conflict with an appointment arises. If an appointment is not cancelled within 24-hour notice, there will be a charge of **$40.00.**

2.) ***Patient Financial Responsibilities:*** The patient (or patient's guardian if a minor) is ultimately responsible for the payment for their treatment and care. We are pleased to assist you by billing your contracted insurers. However, the patient is required to provide us with the most correct and updated information about their insurance and will be responsible for any charges incurred if the information provided is not correct or updated. Patients are responsible for the payment of co-pays, co-insurance, deductibles, and all other procedures or treatment not covered by their insurance plan. Payment is due at the time of service, and for your convenience, we accept cash, check, and most major credit cards at our office. Patients may incur, and are responsible for, the payment of additional charges at the discretion of Dr. Ford & Dr. Fehrman. These charges may include (but are not limited to):

- Charge for returned checks.
- Charge for broken/missed appointments without 24 hours advance notice.
- Charge for the copying and distribution of patient medical records.

3.) ***Co-pays and deductibles:*** As a courtesy, we try our best to verify all Insurance. However, it is the patient's responsibility to know what is or is not covered under their dental plan. It is the full responsibility of the adult patient, the parent of an adult patient that is on the parents account, or the parent of the minor patient, to pay their portion of the dental charges, not covered by the insurance company, at the time of services. Most dental insurance's require co-pay and have deductibles. It is your responsibility as the patient, or parent of the patient to know your insurance policies. The receptionists will assist you to the best of their ability in researching your coverage and costs. However, our office does not set insurance guidelines or co-pays.

4.) ***Minors Financial Responsibilities:*** The guardian who has signed and filled out the minor's paperwork OR the guardian who brings a minor to a scheduled appointment is responsible for the minors' full balance. In the case that a minor's guardians are no longer together, share custody, separated, or another situation where the guardians' split co-pays, deductibles, balance of a minor. It is the responsibility of the guardian with the minor at the time of services to pay the balance in full and contact the other parties who share any financial responsibilities

Please sign and date the lines below to state that you agree and understand all the contents in this letter.

Name _____ Date _____
Print Patient Name

Name _____ Date _____
Signature of patient/guardian

Name _____ Date _____
Print Guardian name if minor

Understanding your Delta Dental Plan's coverage.

Hilltop Dentists is a participating Dental office for Delta Dental PPO and Premier.
What's the difference between Delta Dental PPO and Delta Dental Premier??
The network you should use depends on your plan's coverage.

Use Delta Dentals "Find a Dentist" tool to find an in-network provider that's right for you!

Your Delta Dental Plan covers BOTH providers Dr. Fehrman and Dr. Ford.

Dr. Fehrman is a **Delta Dental PPO** Provider
Dr. Ford is a Delta Dental **Premier** Provider.

PPO

If you're enrolled in a Delta Dental PPO, then your plan is designed to give you the greatest opportunity for savings when you visit an in-network, PPO dentist.

Many PPO plans also come with access to the Delta Dental Premier® network. Since our Premier network is slightly larger than our PPO network, it acts like a "safety net" to ensure you can access in-network care. It's kind of like a network within a network.

Premier

If you have a Delta Dental Premier plan, then you may visit any PPO or Premier dentist. However, premier dentist fees may mean different out-of-pocket costs than PPO dentist fees.
Whether you have a PPO or Premier dental plan, accessing in-network dental care is easy.

We strive to give our patients the best estimates possible, however it is the patient's responsibility to understand their dental plan and what provider they would like to see.

Print Patient Names _____ Date: _____

Patient Signature _____

Hilltop Dentsits
12265 N. State Rd
Otisville, MI 48463
(810) 631-4573
(810) 631-9600

Authorization for Release of Information

By signing this authorization, I authorize the use or disclosure of my individual identifiable health information as described below. I understand that this authorization is voluntary and that I may revoke it at any time by submitting my revocation in writing to the entity providing the information.

I, _____ DOB: _____ hereby authorize
(Print patient's name)

_____
(Former Dental Office Name)

_____
(Former Dental Office Phone number)

To provide/release my dental records with respect to any dental care & treatment, any Periodontal charting and/or any Root Planning & scaling history that I have received & all x-rays taken with-in the last 5 years to:

Hilltop Dentists
Please email all information to:
Office@hilltopdentists.com

I understand that the specific type of information to be disclosed includes a detailed report of examinations, treatment provided, x-rays and all other records which pertain to me.

This consent is effective until such date as I cancel this consent. I understand that the information obtained because of this consent may be used after the cancellation date.

Patient Signature _____

Guardian Signature _____

****YOU MAY REFUSE TO SIGN THIS AUTHORIZATION. ****

THIS AUTHORIZATION IS NOT VALID
IF IT HAS NOT BEEN FILLED OUT COMPLETELY