HILLSIDE DENTAL
of Sage

Patient Information

Patient Name: ____ Date: ______________
Last First

☐ Male ☐ Female ☐ Other ☐ Married ☐ Single ☐ Child ☐ Other______________

Email Address: ______________________________

Birth Date:(DD/MM/YYYY)________/__________/___________

Phone (Mobile) (______) ______-________ (Landline) (______) ______-_______ (Work) (_____) ______-________

Preferred Method of Contact: ☐ Mobile ☐ Landline ☐ Work

Address:____
Apartment # Street

____
City Province Postal Code

Emergency Contact (Name) ___________________(Mobile)____________________(Relationship)___________

Health Information

Date of Last Dental Visit: __________________________ Reason for this visit:___________________________________

Have you ever had any of the following? Please check those that apply:

☐ AIDS/HIV
Allergies
- ☐ Codeine Allergy
- ☐ Penicillin Allergy
- ☐ Other Allergies ______________ ______________

☐ Anemia
☐ Arthritis
☐ Artificial Joints
☐ Asthma
☐ Blood Disease

☐ Cancer
☐ Diabetes
☐ Dizziness
☐ Epilepsy
☐ Excessive Bleeding
☐ Fainting
☐ Glaucoma
☐ Growths
☐ Hay Fever
☐ Head Injuries
☐ Heart Disease
☐ Heart Murmur
☐ Hepatitis (A B C)

☐ High Blood Pressure
☐ Jaundice
☐ Kidney Disease
☐ Liver Disease
☐ Mental Disorders
☐ Nervous Disorders
☐ Pacemaker
☐ Pregnancy (currently)
Due date: __________
☐ Radiation Treatment
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Rheumatism

☐ Sinus Problems
☐ Stomach Problems
☐ Stroke
☐ Tuberculosis
☐ Tumors
☐ Ulcers
☐ Venereal Disease

OTHER:

☐ __________________

☐ __________________

Please list any medications and or supplements you currently take:

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain:
  ____

- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain:
  ____

- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain:
  ____

- Name of Physician: ________________________________ Phone:____________________

- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain:
  ____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

____ Date: ____________________
Signature of patient, parent or guardian

____
Signature of Doctor

Photo Release Consent

I consent to the release of photos for the use of promotional material for Hillside Dental of Sage. Uses include but are not limited to the website material, social media and physical promotions.

____
Patient Initials

Referral Information

Whom may we thank for referring you to our practice? ☐Another patient ☐ Signage

☐ Dental Office ☐ Neighborhood ☐ Google/Internet/website ☐ School ☐ Work ☐ Other____________________

Name of person or office referring you to our practice: ________________________________

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

____ Date: ____________ Relationship to Patient: __________

Signature of patient, parent or guardian (if applicable)

Credit Card Authorization

I ______________________________ authorize Hillside Dental of Sage to process a charge to my credit card at the time my balance is due for any services rendered where the remaining balance is under $50.00. Anything over the amount of $50.00, I will be contacted prior to any payment being processed.

Full name on card: ________________________________ Type of Credit Card: ________________________

Card Number: ____

Expiry Date:_________________________ CVV__________________

____ _________________________

Signature of patient, parent or guardian Date