Black Hills
IMPLANT AND FAMILY DENTAL

Dr. Brian L. Hettinger, D.D.S.

Date ________________

Name _______________________________________ Soc. Sec. # _______________________________

Home Phone#______________ Cell#_______________ Email___________________________________

Address __________________________________ City _______________ State _____ Zip __________

Sex □ M □ F Age ___ Birthdate ________ □ Single □ Married

Patient Employer ______________ Occupation ______________ work phone#_________OK to call work?__

Parent (if under 18)/Spouse _____________________ Employer _________________

Whom may we thank for referring you? ______________________________________

People authorized for release of information? _________________________________

Account Information

Person Responsible for Account __________________________________

Relation to Patient ________________ Birthdate _________ Soc. Sec. # _______________

Address ____

City _________________________ State _______ Zip _________________________

Insurance Information

Insurance Company ________________________Address__________________ Phone # __________

ID # ______________ Group # _____________ Employer Name _______________________________

Subscriber Name ________________ Address _______________ City __________ State ___ Zip_____

Relation to Patient __________ Birthdate _______ Phone # __________ Soc. Sec. # _______________

Secondary Insurance Company ________________Address ____________________ Phone #
____

ID # ______________ Group # _______________ Employer Name _______________________________

Subscriber Name ________________ Address ________________ City _________ State ___ Zip _______

Relation to Patient __________ Birthdate _______ Phone # __________ Soc. Sec. # _______________

Dental History

Reason for today's visit ______________________________Former Dentist ___________Date last Exam____________

Medical History

Physician's Name ____________________________ Date of Last Physical __________________

Physician's Address ___________________________ Phone # ____________________________

(Women)Are you pregnant? □Y □N Nursing? □Y □N Taking birth control? □Y □N

Check (√) if you have or have had any of the following:

□ HIV/AIDS
□ Hepatitis (type _____)
□ Tuberculosis
□ Artificial Joint (where/when)______
□ Artificial Heart Valves
□ Heart Murmur
□ Heart Problems/stent___________
□ Mitral Valve Prolapse
□ Pacemaker/implanted defibrillator
□ High or Low Blood Pressure
□ Scarlet Fever
□ Rheumatic Fever
□ Skin Rash, hives

□ Thyroid Problems
□ Anemia or Blood Disorder
□ Arthritis, Rheumatism, Lupus
□ Back or Neck Problems
□ Cortisone Treatments
□ Osteoporosis (taking medication)
□ Headaches
□ Epilepsy, seizures, fainting
□ Asthma
□ Emphysema, COPD
□ Diabetes
□ Sleep Apnea
□ Tobacco Habit

□ Ulcer, Acid Reflux, digestive disorders
□ Stroke (taking blood thinners)
□ Kidney or Liver Disease
□ Cancer (where/when) _____________
□ Chemotherapy
□ Radiation Treatment
□ Transplant (where/when)__________
□ Emotional/Anxiety Issues
□ Psychiatric Care
□ Jaw Pain/ TMJ
□ Dry Mouth
□ Cold Sores (frequent)

Medications	**Purpose**	**Allergies**	**Supplements**
___________________	_________________________	___________________	____________________
___________________	_________________________	___________________	____________________
___________________	_________________________	___________________	____________________
___________________	_________________________	___________________	____________________

Authorization

I hereby authorize my insurance benefits to be paid directly to the dentist. I authorize the use of this signature on all insurance submissions and I authorize the dentist to release all information necessary for this claim. I understand that I am financially responsible for all charges whether or not paid by insurance.
I consent to the making of photographs, and x-rays before, during and after treatment and I consent to the use of my records by the doctor if he so determines.
In consideration of the services rendered by this dental office, I am obligated to pay said office in accordance with its credit terms and policy.

I confirm that I have read or had a copy of the Black Hills Implant and Family Dental **Notice of Privacy Practices** given to me.

I certify that I have read or had read to me the contents of this form and do realize the risks and limitations involved.

Signature ________________________ Print Name_________________________ Date ______________

Payment is due in full at time of treatment unless prior arrangements have been approved