

# Hillview Family Dentistry

119 Topfield Rd  
Louisville, KY 40229  
502-957-4408

## Dental History

Any sensitivity? (Y/N) \_\_\_\_\_ (Hot, Cold, Sweet)  
Where? UL, UR, LL, LR  
Headaches, earaches, neck pain, jaw joint pain? (Y/N) \_\_\_\_\_  
Teeth or fillings breaking? (Y/N) \_\_\_\_\_  
Grinding or clenching teeth? (Y/N) \_\_\_\_\_  
Bleeding, swollen or irritated gums? (Y/N) \_\_\_\_\_  
Loose, Tipped or shifting teeth? (Y/N) \_\_\_\_\_  
Bad Breath? (Y/N) \_\_\_\_\_  
Do you have, or have you had any of the following? (Y/N) \_\_\_\_\_  
Denture, Partial dentures, Braces, Periodontal (gum) disease?

Your last cleaning? \_\_\_\_\_  
Your last oral cancer screening? \_\_\_\_\_

Do you smoke or use chewing tobacco? (Y/N) \_\_\_\_\_  
How much? \_\_\_\_\_ How Long? \_\_\_\_\_  
If I could change my smile, I would: (circle)  
Make them whiter  
Make them straighter  
Close Spaces  
Replace black metal fillings with tooth colored restorations  
Replace old crowns that don't match

Your previous Dentist? \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_

On a scale of 1-10 10 being the highest rating:

How important is your dental health to you? \_\_\_\_\_

Where would you rate your current dental health? \_\_\_\_\_

Where do you want your dental health to be? \_\_\_\_\_

Why did you leave your previous dentist? \_\_\_\_\_

\_\_\_\_\_

What is the most important thing to you about your future smile and dental health?

\_\_\_\_\_

What is the most important thing to you about your dental visit today?

\_\_\_\_\_

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## Health History

What medications are you currently taking?

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If female are you taking birth control pills? (Y/N) \_\_\_\_\_

Are you pregnant? (Y/N) \_\_\_\_\_

Are you nursing? (Y/N) \_\_\_\_\_

Please circle any conditions that pertain to your health.

Any questions please ask front desk or dentist.

Abnormal Bleeding

Allergies

Heart Attack

Angina Pectoris

Hepatitis A

Hepatitis B

HIV + AIDS

Liver Disease

Diabetes

Pneumocystitis

Emphysema

Fainting Spells

Frequent Headaches

Glaucoma

Hay Fever

Tuberculosis

Hemophilia

Yellow Jaundice

Asthma

Cancer/Chemo

Cosmetic Surgery

Mitral Valve Prolapse

Psychiatric Problems

Rheumatic Fever

Shingles

Sinus Problems

Alcohol abuse

Thyroid Problems

Heart Surgery

Venereal Disease

Artificial Bones

High Blood Pressure

Kidney Problems

Low Blood Pressure

Difficulty Breathing

Drug Abuse

Epilepsy

Fever Blisters

Stroke

Anemia

Ulcers

Arthritis

Artificial Heart Valve

Blood Transfusion

Colitis

Congenital Heart Defect

Pace Maker

Radiation Therapy

Seizures

Sickle Cell Disease

Explain any other condition if not listed: \_\_\_\_\_

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Allergies: Aspirin Codeine Erythromycin Jewelry Latex Metals Penicillin Tetracycline:

Others: \_\_\_\_\_



## Hillview Family Dentistry

Today's Date: \_\_\_\_\_

Patient's Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Employer: \_\_\_\_\_ Work Number: \_\_\_\_\_

E - Mail address: \_\_\_\_\_

Home Phone Number: \_\_\_\_\_ Cell Number: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Person Responsible for account: \_\_\_\_\_

Driver License Number: \_\_\_\_\_

How did you hear of our office? \_\_\_\_\_

Dental Insurance: Y N Insured Name: \_\_\_\_\_

Insured's Social Number: \_\_\_\_\_ D.O.B. \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Insurance Company Address: \_\_\_\_\_

Insured Employer: \_\_\_\_\_ Phone Number: \_\_\_\_\_

ID Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Secondary Insurance: Y N Insured Name: \_\_\_\_\_

Insured's Social Number \_\_\_\_\_ D.O.B. \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Insurance Company Address: \_\_\_\_\_

Insured Employer: \_\_\_\_\_ Phone Number: \_\_\_\_\_

ID Number: \_\_\_\_\_ Group Number: \_\_\_\_\_



## Hillview Family Dentistry

### Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations. (HIPPA)

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and 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 among the many health professionals who contribute to my care.
- a source of information for applying my diagnosis and surgical information to my bill
- a means by which a third-party payer can verify that services billed were actually provided.
- and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided. 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.

I request the following restrictions to the use or disclosure of my health information.

Accepted \_\_\_\_\_ Denied \_\_\_\_\_

Signature of Patient or Legal Representative: \_\_\_\_\_

Today's Date: \_\_\_\_\_