HEALTHY, CONFIDENT SMILES
HILLS DENTAL
RACHANA VYAS DDS

1002 S. De Anza Blvd, #D,
San Jose, CA 95129
(408) 675-0998
hillsdentaldds@gmail.com

Date _____

Patient Information...

❑ Mr.. ❑ Mrs.. ❑ Ms.. ❑ Dr.. First Name _____ M..I.. ____ Last Name _____

Sex: ❑ Male ❑ Female Birth Date _____ Age ____ Soc.. Sec.. # _____ E-mail _____

Street _____ Apt. ____ City _____ State _____ Zip _____

Home Tel..(____) _____ Cell..(____) _____

Referred By _____ _____
First Name Last Name

In case of emergency, please contact _____ Tel.. (____) _____ Relation _____

Spouse or Other guarantor information (If different from above)...

Name _____ _____ Relation _____ S..S..# _____ Birth Date _____
First Name Last name

Street _____ Apt. ____ City _____ State _____ Zip _____

Tel.. (____) _____ Employer _____ Bus.. Tel..(____) _____

Insurance information...

Student:..... ❑ Full Time ❑ Part Time ❑ Not

Marital Status:..... ❑ Married ❑ Divorced ❑ Widow ❑ Single

Employed:..... ❑ Full Time ❑ Part Time ❑ Retired ❑ Not

Primary insurance company...

Dental Insurance Type: ❑ PPO ❑ HMO ❑ Other

Ins.. Co.. Name _____ I..D.. # _____ Group # _____

Insured Party _____ Relation _____ Sex: ❑ M ❑ F Birth Date _____ S..S.. # _____
First name last name

Dental Information...

Reason for today's visit _____ Are you in pain? ❑ Yes ❑ No

Please indicate any of the following problems by checking off the corresponding box:

❑ Lost / broken filling(s) ❑ Bad breath ❑ Broken / chipped tooth ❑ Toothache
❑ Teeth grinding / clenching ❑ Gum disease
❑ Other _____

Last dental exam _____ Last dental x–rays _____

How would you rate your smile? (worst) 1 2 3 4 5 6 7 8 9 10 (best)

Medical History…

Do you have, or have you had, any of the following diseases, medical conditions, or procedures?

Y N	Y N	Y N	Y N
❑ ❑ Rheumatic fever	❑ ❑ Mental health problems	❑ ❑ Jaundice / Liver disease	❑ ❑ Arthritis / Joint disease
❑ ❑ High blood pressure	❑ ❑ Delay in healing	❑ ❑ Hepatitis	❑ ❑ Joint replacement
❑ ❑ Low blood pressure	❑ ❑ Sleep apnea / CPAP	❑ ❑ Gallbladder trouble	❑ ❑ Stomach ulcers
❑ ❑ Mitral valve prolapse	❑ ❑ Respiratory problems	❑ ❑ Convulsions / Epilepsy	❑ ❑ Cancer / Radiation / Chemotherapy
❑ ❑ Heart murmur	❑ ❑ Tuberculosis	❑ ❑ Stroke	
❑ ❑ Chest pain / Angina	❑ ❑ Emphysema	❑ ❑ Thyroid trouble	
❑ ❑ Heart attack(s)	❑ ❑ Do you smoke	❑ ❑ Diabetes	
❑ ❑ Cardiac pacemaker	❑ ❑ A history of drug abuse	❑ ❑ Low blood sugar	
❑ ❑ Heart surgery	❑ ❑ A history of alcohol abuse	❑ ❑ Kidney trouble	
❑ ❑ Pneumonia / Bronchitis / Chronic cough	❑ ❑ Abnormal bleeding	❑ ❑ Sexually transmitted diseases	
❑ ❑ Anemia	❑ ❑ Blood disorder	❑ ❑ Contagious diseases	
❑ ❑ Asthma	❑ ❑ Bruise easily	❑ ❑ Infectious mononucleosis	

Medication and Allergies…

Please list any other medication(s) you are taking (including natural, herbal, or homeopathic products):

Medication	Dosage	Frequency	Medication	Dosage	Frequency

Are you allergic to, or had a reaction to:

Y N	**Y N**	**Y N**	**Y N**
❑ ❑ Penicillin	❑ ❑ Sulfa drugs	❑ ❑ Aspirin	❑ ❑ Codeine or other narcotics
❑ ❑ Latex	❑ ❑ Do you have any known allergies		

Please list any other medication or antibiotic you are allergic to:

Medication / Antibiotic name	Medication / Antibiotic name

1- 4 below for women only: *(Women note: antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician / gynecologist for assistance regarding additional methods of birth control.)*

1) Is there a possibility of pregnancy? ❑ Yes ❑ No **2)** Expected delivery date: _____

3) Are you nursing? ❑ Yes ❑ No **4)** Are you taking birth control pills: ❑ Yes ❑ No

I certify that I have read and I understand the questions above.. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction.. I will not hold my doctor, or any other member of his / her staff, responsible for any errors or Omissions that I have made in the completion of this form..

X _____ **X** _____ **X** _____

Signature of patient *(Parent or Guardian if Minor)* **Reviewed by** **Date**

Fees & Payments

I understand that I am Financially responsible for all charges whether or not paid by insurance.. We make every effort to keep down the cost of your care..Other arrangement can be made with our office..

A specific amount of time is reserved especially for you and we strongly encourage all patients to keep their appointments. If you must change your appointment, we require at least 24 hour notice to avoid a **$25 cancellation** fee (emergencies are an exception).

X _____ **X** _____

Signature of patient *(Parent or Guardian if Minor)* **Date**

This signature on file is my authorization for the release of information necessary to process my claim.. I hereby authorize payment to this doctor named of the benefits otherwise payable to me..

X _____ **X** _____

Signature of patient: *(Parent or Guardian if Minor)* **Date**

I hereby acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice..

X _____ **X** _____

Signature of patient *(Parent or Guardian if Minor)* **Date**