Hilde Family Dentistry
Jason L. Hilde, D.D.S., P.L.L.C.

Welcome to Hilde Family Dentistry

Patient Record

Name _____ Date of Birth _____ Age _____

Address _____

City _____ State _____ Zip _____ Email _____

Home Phone _____ Cell Phone _____ Work Phone _____

Employer _____ Occupation _____ SSN _____

Insured's Name _____ Insured's Date of Birth _____

Insured's Employer _____ Insured's SSN _____

Emergency Contact: Name _____ Phone _____

Whom may we thank for referring you? _____

Financial

There will be a $50.00 per hour charge for missed appointments or late notice cancellations. Hilde Family Dentistry requires 48 hours notice if unable to keep my appointment. This does not include Friday, Saturday or Sunday.

Hilde Family Dentistry will submit a dental insurance claim as a courtesy. I understand and acknowledge Hilde Family Dentistry is not responsible for any incorrect or incomplete insurance benefit information. If my insurer denies coverage or if Hilde Family Dentistry otherwise does not receive payment within 45 days from filing my claim, the amount will then become due and payable by me. I will not withhold payment because of insurance or third-party involvement.

I authorize payment to be made directly to Jason L. Hilde D.D.S., P.L.L.C. by my insurance company. I understand I am fully responsible for all services rendered and that payment is due at time of service. For insurance patients, this is the estimated patient portion of your insurance benefit. Fee quotes are honored for 90 days.

Informed Consent

This is my consent to the dental procedures and treatment to be performed by Dr. Hilde and his supporting team. I agree to the use of local anesthesia, sedation and/or analgesia as needed and determined by Dr. Hilde

I understand that medications for discomfort and sedation may cause drowsiness which can be increased by the use of alcohol or other drugs. I will avoid operating any vehicle or hazardous mechanical devices while taking such medications. I realize that I may develop allergic or hypersensitive reactions to medications and will report them to Dr. Hilde immediately. It is also my responsibility to report any changes in my medical status to this office. I authorize release of any information concerning my (or my child's) health care, advice and treatment: (1) provided for the purpose of evaluation and administering claims for insurance benefits or (2) to another dentist or health care provider.

I have read and understand the above information and have answered the above questions to the best of my knowledge.

Patient/Guardian Signature _____ Date _____

Staff Member Initials _____ Date _____