Hillside Dentistry
2951 Ranch Road 620 South
Suite 175
Austin TX 78738
(512)263-2255

Patient Information

Please Fill Out The Information Below In Order To Help Us Serve You Better. Thanks, The Staff At Hillside Dentistry.

Patient Name:

Last: ______________________ First: _____________________ Nickname: _______________

Phone Num. Home: ________________ Cell: _________________ Work: _________________

Birthday: ___________________ SSN: ___________________

Gender

○ Male ○ Female ○ Transgender

Family Status

○ Married ○ Single ○ Divorced ○ Widowed ○ Partnered

Email Address: ____

Home Address: ____

____

Pharmacy Name: _________________________ Phone: _______________ Fax: ______________

Primary Dental Insurance Information

Information About Insurance Card Holder

Insured's Relationship To Patient:

○ Patient ○ Spouse ○ Parent/Guardian

Name Of Card Holder: (If Different From Patient) ______________________________

Address Of Card Holder: (If Different From Patient) _____________________________

____

Hillside Dentistry (512)263-2255

2951 Ranch Road 620 South

Suite 175

Austin TX 78738

Email Address: ______________________________Birthday: ___________________

Home Phone: ________________ Work:________________Cell:_______________

SSN OR Driver's License Of Card Holder: _______________________________
(Some Insurance Companies Require This To Confirm Insurance. If You Know Your Company Does Not Require This Please Do Not Write It Down.)

Gender

◯ Male ◯ Female ◯ Transgender

Insurance Information

ID Number: ______________________ Group Number: _______________________

Insurance Name: ____________________________ Phone Number: _________________

Insurance Address: ____

____

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: ______________________ Phone: __________

Address: ______________________ ______________________

______________ City ______ State ______ Zip Code

We Ask For Your Medical Insurance Because Some Dental Procedures Can Be Filed Under Both Medical And Dental Insurance. We Will File The Relevant Procedure Under Your Dental Insurance First, If There Is Any Balance Remaining We Will Be Happy To Then File It Under Your Medical Insurance. This Is Not A Guarantee Of Payment On Either Inurance's Behalf. If You Prefer To Not Have Us File Your Medical Insurance Please Refrain From Filling Out The Information Below And Please Mark The Box "No"For The Question, "Please File My Medical Insurance." Please Know That Any Remaining Balance After We Have Filed Any Relevant Dental Insurance Is The Sole Responsibility Of The Patient.

Note: We Will ONLY File Your Medical Insurance If A Procedure Has Been Done That Is Allowable To Be Filed Under

Hillside Dentistry (512)263-2255

2951 Ranch Road 620 South

Suite 175

Austin TX 78738

Your Medical Insurance. If You Have Medical Insurance But Not Dental Insurance And You Agree For Us To File The Relevant Procedure, Any Remaining Balance Is The Sole Responsibility Of The Patient. Having Medical Insurance Is Not A Guarantee Of Payment.

Please File My Medical Insurance

◯ Yes ◯ No

Medical Insurance Information

Insurance Card Holder's Name: ____________________

Address: ____________________

Email Address: ____________________ Birthday: ____________________

Home Phone: ____________ Work: ____________ Cell: ____________

Patient's Relationship To Insured

◯ Self ◯ Spouse ◯ Parent/Guardian

ID Number: ____________ Group Number: ____________

Insurance Name: ____________ Phone Number: ____________

Insurance Address: ____________________

____

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: ____________ Phone: ____________

Address: ____________ ____________

____________ City ____ State ____________ Zip Code

Response Date: ____________

Hillside Dentistry Health History Form

Fill In The Box Only If The Patient Has Now OR Ever Had In The Past.

Patient Name:________________________ Birthday_______________ ☐ Male ☐ Female

Cardiovascular (Heart)

- O High Blood Pressure (Hypertension)
- O Irregular Heart Beat, Pacemaker (Arrhythmia)
- O Chest Pain (Angina)
- O Heart Attack (MI)
- O Mitral Valve Prolapse
- O Heart Murmur
- O Prosthetic Heart Valve
- O Heart Surgery: Bypass, Transplant, or Stent

Gastrointestinal (Digestive)

- O Hepatitis
- O Cirrhosis
- O Ulcer(s)
- O Transplant: Liver or Kidney
- O Heartburn or Reflux
- O Irritable Bowl
- O Crohn's Disease or Ulcerative Colitis

Endocrine

- O Diabetes
- O Thyroid: Please Circle Hyper Hypo
- O Prostate Problem
- O Adrenal Disorder

Pulmonary (Lungs)

- O Asthma
- O Emphysema or Bronchitis
- O Pneumonia
- O Tuberculosis
- O PPD+
- O COPD

Nervous System

- O Alzheimer's Disease or Other Dementia
- O Schizophrenia
- O Depression, Phobia, or Severe Anxiety Disorder
- O Seizure or Epilepsy
- O Headaches, Frequent or Severe
- O Stroke (CVA)
- O Degenerative Disorders or Paralysis (Parkinson's, MS, Cerebral Palsy, or Muscular Dystrophy)

Musculoskeletal

- O Artificial Joint
- O Degenerative Arthritis
- O Rheumatoid Arthritis

Genitourinary (Kidneys & Urinary)

- O Dialysis
- O Syphilis, Gonorrhea, or Herpes

Hematologic (Blood)

- O Anemia (Not Sickle Cell)
- O Bleeding Disorder (Not Hemophilia)
- O Bone Marrow or Stem Cell Transplant
- O Blood Transfusion
- O Leukemia, Blood Cancer, Lymphoma, or Multiple Myeloma
- O Sickle Cell Anemia or Sickle Cell Trait
- O Hemophilia

Immune System

- O Allergy To Food, Metals, or Jewelry
- O Allergy To Medication (Details On Next Page)
- O Allergy To Latex
- O HIV or AIDS
- O Lupus
- O Sjogren's Syndrome

Dermatology (Skin)

- O Rash/Hives/Sores

Cancer

- O Any History of Cancer: Please List Below
- O

Drug Use

- O Prior or Current Injection Drug Use
- O Prior or Current Non-Injection Recreational Drug Use

Women

- O I Am Pregnant or Possibly Pregnant
- O I Am Nursing
- O Post-Menopause
- O I Take Oral Contraceptives

The above medical history has been reviewed by me and is complete and accurate.

Patient Signature: ____Date:____________________

This Section Is For Office Use Only

Patient Name: _______________________________ Date: _________________ Chart # _____________________

Vital Signs

Blood Pressure: ___________/___________ Pulse Rate: ___________ Weight: ___________ Height: ___________

Health History: Please Clarify All Positive Responses From the Health History and Review of Systems Forms.

Issue/ Item: **Notes:**

1. ____
2. ____
3. ____
4. ____
5. ____
6. ____

List All Medications: Please Include All Prescription and Over-the-Counter Medications As Well As Any Vitamins and Supplements You Are Currently Taking.

Medication: **Dose:** **Times Per Day Taken:** **Reason Taken:**

1. ____
2. ____
3. ____
4. ____
5. ____
6. ____
7. ____
8. ____
9. ____
10. ____

Allergies: Please List All Allergies to Medication and Nature of the Reaction:

1. ____
2. ____
3. ____
4. ____

Please Circle If You Have Any of the Following Allergies:

Latex **Shellfish** **Iodine** **Lidocaine**

Hillside Dentistry Review of Systems & Oral History

Please Update Once a Year & For New Patients

Patient Name:________________________________ Birthday:______________ Today's Date: ______________

Review of Systems: Fill In The Box ONLY If You Currently Have or Have Had In The Past.

- O Significant Change In Vision or Hearing
- O Chest Pains
- O Numbness or Tingling In Fingers, Toes, or Face
- O Shortness Of Breath
- O Loss Of Appetite
- O Frequent Thirst
- O Muscle Weakness
- O Significant Fatigue or Tiredness
- O Lumps, Bumps, Rash, or Sores On Skin or In Mouth
- O Dry Mouth
- O Heart Palpitations
- O Persistent Cough
- O Frequent Headaches
- O Frequent Abdominal Pain
- O Frequent Urination
- O Significant Muscle Pain
- O Feeling Depressed, Anxious, or Nervous
- O Bloody Nose, Stool, or Urine
- O Difficulty Swallowing
- O Swollen Ankles
- O Frequent Dizziness or Fainting
- O Frequent Upset Stomach
- O Frequently Hungry
- O Significant Joint Pain
- O Limited Range Of Motion
- O Unexplained/Unintended Weight Loss

Social History:

Alcohol Use	Other Liquor	Beer
O Never Drink Alcohol	O Less Than Daily	O Less Than Daily
O Recovered From Dependency	O 2 or Fewer Each Day	O 2 or Fewer Each Day
O Stopped Drinking Alcohol _____ Yrs. Ago	O More Than 2 Per Day	O More Than 2 Per Day

Tobacco Use	Cigarettes	Chew Tobacco	Cigars	Pipe
O Never Use Tobacco	O Less Than 1 Pack A Day	O At Least Daily	O At Least Daily	O At Least Daily
O Tobacco Cessation	O About 1 Pack A Day	O At Least Weekly	O At Least Weekly	O At Least Weekly
O Stopped Using _____ Years Ago	O More Than 1 Pack A Day	O Monthly or Less	O Monthly or Less	O Monthly or Less

Dental History: Date Of Last Dental Visit: ______________Reason For Last Dental Visit: ____________________________

Reason For Past Dental Care:
- O Mostly Regular Visits
- O Mostly Emergency Visits
- O Other: ______________________________

Oral Hygiene Practices:
- O Brush Teeth Once Daily
- O Brush Teeth More Than Once Daily
- O Do Not Brush Teeth Daily
- O Floss Daily
- O Floss Occasionally
- O Never Floss

Missing Teeth:

☐ Yes ☐ No ☐ Some ☐ All

Prostheses:

☐ Full Upper ☐ Full Lower

☐ Partial Upper ☐ Partial Lower

Oral Function:
- O Difficulty Chewing Food
- O Pain When Opening/Closing Jaw
- O Limited Ability To Open/Close Jaw
- O Jaw Locks Open or Closed
- O Loss Of Taste or Smell
- O Diminished Taste or Smell

Habits:
- O Biting or Sucking The Lip or Cheek
- O Tongue Thrusting, Finger Sucking, or Nail Biting
- O Clenching or Grinding Teeth

Types Of Past Dental Therapy:
- O No History Of Caries (Cavities)
- O Caries Restoration During The Last Year
- O Caries Restoration More Than 1 Year Ago
- O Extraction(s)
- O Tooth/Teeth Bleaching
- O Other Cosmetic Dentistry
- O Orthodontics
- O Root Canal Therapy
- O Dentures
- O Crowns or Bridges
- O Implants
- O Sealants
- O Periodontal Therapy ☐ Surgical ☐ Non-Surgical

Chronic Oral or Facial Pain: (Past or Current)
- O No
- O Jaw/Face/TMJ
- O Burning Tongue or Mouth

Oral Lesions: (Past, Current, or Recurrent)
- O No
- O Mouth
- O Lips

Family History: Mother, Father, Brother, Sister, Daughter, Son, And Blood Related Aunt or Uncle Has or Has Had:
- O Diabetes
- O Heart Attack
- O Cancer
- O Bleeding Disorder
- O High Blood Pressure