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)_____

_____

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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.

Name:_____ DOB:_____ Chart #: _____ 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
- O High Cholesterol

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:_____

Hillside Dentistry Review of Systems & Oral History

Please Update Once a Year & For New Patients

Patient Name:_____ DOB:_____ Chart #: _____

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
- O Never Drink Alcohol
- O Recovered From Dependency
- O Stopped Drinking Alcohol _____ Yrs. Ago

Other Liquor
- O Less Than Daily
- O 2 or Fewer Each Day
- O More Than 2 Per Day

Beer
- O Less Than Daily
- O 2 or Fewer Each Day
- O More Than 2 Per Day

Tobacco Use
- O Never Use Tobacco
- O Tobacco Cessation
- O Stopped Using _____ Years Ago

Cigarettes
- O Less Than 1 Pack A Day
- O About 1 Pack A Day
- O More Than 1 Pack A Day

Chew Tobacco
- O At Least Daily
- O At Least Weekly
- O Monthly or Less

Cigars
- O At Least Daily
- O At Least Weekly
- O Monthly or Less

Pipe
- O At Least Daily
- O At Least Weekly
- 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

Please Confirm That All of the Prior Information is Correct. Thank You.

Signature: _____ Date: _____

Name: _____ Date: _____ Chart #: _____

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**

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Health Insurance Portability Accountability Act (HIPAA), 1996

http://www.hhs.gov/ocr/privacy/hipaa/understanding/summary/index.html

TO THE PATIENT OR PARENT/GUARDIAN — PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to Hillside Dentistry, PLLC's use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Hillside Dentistry, PLLC 2951 RR 620 South, Ste. 175, Austin, TX 78738 Phone: (512)263-2255 Office Manager: Amanda Essig

Acknowledgement of Receipt
Notice of Privacy Practices

Purpose: This form is used to obtain acknowledgement that you have been notified that our Notice of Privacy Practices can be obtained via our office. You may also visit the following website: http://www.hhs.gov/ocr/privacy/hipaa/understanding/summary/index.html

PLEASE FILL OUT THE FOLLOWING INFORMATION:
YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT. PLEASE ADVISE US IF YOU WANT A COPY.
You May Refuse to Sign This Acknowledgement.

I,(Print Name) _____ have had full opportunity to read and consider the contents of this Consent form and Hillside Dentistry, PLLC's Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent for the use and disclosure of my protected health information to carry out treatment, payment activities, and daily health care operations.

Signature: _____ **Date:** _____

If a personal representative signs this Consent on behalf of the patient, please complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

For Office Use:

The staff at Hillside Dentistry, PLLC attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because: (Please Initial)

_____ (Patient) _____ (Office Staff) Individual refused to sign.

_____ Communication barriers prohibited obtaining the acknowledgement.

_____ An emergency situation prevented us from obtaining an acknowledgement.

_____ Other (Please Specify)

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action Hillside Dentistry, PLLC took in reliance on this Consent before they received your revocation, and that Hillside Dentistry, PLLC may decline to treat you or to continue treating you if you revoke this Consent.

REVOCATION OF CONSENT

I revoke my Consent for Hillside Dentistry's use and disclosure of my protected health information for treatment, payment activities, and daily healthcare operations. I understand that revocation of my Consent will not affect any action Hillside Dentistry, PLLC took before they received this written Notice of Revocation. I also understand that Hillside Dentistry may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: _____ Date: _____

Non-covered Services Acknowledgement Form

I understand that the services performed by and/or supplies prescribed by the treating doctor and the office of Hillside Dentistry, PLLC may not be considered eligible for benefits by my insurance carrier. I understand that my insurance coverage has certain restrictions, as well as non-covered services and supplies.

Nearly all dental benefit plans are the result of a contract between the plan sponsor (usually an employer or a union) and the third-party payer (usually an insurance company). The amount the plan pays is determined by the agreement negotiated by the employer with the insurer. Dental coverage is determined not by the patient's dental needs, but by how much the employer contributes to the plan.

If my dependent or I choose to receive the services and/or supplies prescribed by the treating doctor and they are not covered by my insurance, I agree in advance to accept full financial responsibility for all costs associated with the non-covered services.

_____ _____

PATIENT SIGNATURE OFFICE MANAGER'S SIGNATURE

_____ _____

DATE DATE

Financial Agreement

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment. Additionally, fee estimates are valid for a period of six months following the date of consultation.

All emergency dental services and any dental services performed without previous financial arrangements must be paid for at the time services are rendered.

Patients who carry dental insurance will be financially responsible for any deductibles, co-payments, and/or fees for non-covered services on the date of service. This office will help prepare the patient's insurance forms and assist in making collections from insurance companies, and will credit any collections from insurance to the patient's account. This dental office cannot render services on the assumption that the resulting charges will be covered by insurance.

For those patients whose insurance is considered out-of-network with this office, the following applies. This office will file your insurance, and any remaining balance will be written off so there is a zero patient balance for services rendered on that date. This only applies after all applicable deductibles, co-payments, and/or fees for non-covered services. We believe it is the patient's right to decide where they go for treatment, and we therefore don't want to "punish" you if your insurance is considered out-of-network. This is a courtesy to our patients as we are allowed to collect the difference in fees. This only applies to services normally covered by the patient's insurance company.

For services rendered where a set fee is given for a non-covered service, the patient will be responsible for payment of that fee. This applies to both in-network and out-of-network insurance plans. For services that are not covered by the patient's insurance plan, fees will be set by either discounts set per the patient's insurance company or, in the absence of such discounts, will be at the normal office fees.

For prosthetic services the following applies: for those without insurance, 50% of the fee is due when impressions are taken. For insurance patients, your portion of the co-payment is due when impressions are taken.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment, or within ten (10) days of billing. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

If there is any uncertainty as to the financial agreement, please speak with Amanda, the office manager. As matters arise, it may be helpful to speak over the phone. Therefore, this document grants permission for this office to contact the patient and/or the responsible party about matters related to this form.

May We Contact You By Email or Text For Appointment Reminders? **YES** **NO**

I have read the above conditions of treatment and payment and agree to their content.

Signature of patient/guarantor: _____ Date: _____