Welcome! We are pleased you have chosen us to care for your dental health. Please help us by taking a minute to fill out this entire packet. We promise that all of this information will remain confidential.

Date: _____

PATIENT INFORMATION

Name:_____
(Last) (First) (Middle initial) (Nickname)

Home Address:_____

_____
(City) (State) (Zip)

Home Phone:_____ **Cell Phone:**_____**Email:**_____

Date of Birth:_____ **Sex: Male Female**

Emergency Contact Name and Number:_____

Whom may we thank for referring you to us?_____

PARENT/RESPONSIBLE PARTY

Person responsible for bill:_____
(Last) (First) (Middle initial)

Date of birth:_____

Responsible Party's Address:_____
(Street)

_____**Relationship to patient:**_____
(City) (State) (Zip)

Responsible Party's Home Phone:_____ **Business:**_____

Responsible party's Employer:_____

Employer's Address:_____

INSURANCE INFORMATION

As a courtesy we will accept payment of benefits directly from your insurance company. Please fill this part of accurately and completely. The part of our fee that is not covered by insurance is due at the time of treatment.

Name of insurance company:_____

Address of insurance company:_____
(Street) (city) (State) (Zip)

Name of insured:_____
Employee:_____

Group Number:_____ **Social Security Number:**_____ **Date of birth of insured:**_____

ID#_____ **Do you have secondary insurance: Yes No**

For the following questions mark yes or no. The answers are for office records only and will be considered confidential. A thorough and complete history is vital to a proper dental evaluation.

Medical History

Patient Profile:

YES NO Does the patient follow directions well?
YES NO Does the patient brush his/her teeth conscientiously?
YES NO Does patient have learning disabilities or need extra help with instructions?
YES NO Is patient sensitive or self-conscious about teeth?

Medical History:

Now or in the past, has the patient had:
YES NO Birth defects or hereditary problems?
YES NO Bone fractures, any major accidents?
YES NO Rheumatoid or arthritic conditions?
YES NO Endocrine or thyroid problems?
YES NO Kidney problems?
YES NO Diabetes?
YES NO Cancer, tumor, radiation treatment or chemotherapy?
YES NO Stomach ulcer or hyperacidity?
YES NO Polio, mononucleosis, tuberculosis, pneumonia?
YES NO Problems of the immune system?
YES NO AIDS or HIV positive?
YES NO Hepatitis, jaundice or liver problems?
YES NO Fainting spells, seizures, epilepsy or neurological problems?
YES NO Mental health disturbance or depression?
YES NO Vision, hearing, tasting or speech difficulties?
YES NO Loss of weight recently, poor appetite?
YES NO History of eating disorder (anorexia, bulimia)?
YES NO Excessive bleeding or bruising tendency, anemia or bleeding disorder?
YES NO High or low blood pressure?
YES NO Tired easily?
YES NO Chest pain, shortness of breath or swelling ankles?
YES NO Cardiovascular problems (heart trouble, heart attack, angina, coronary insufficiency, arteriosclerosis, stroke, inborn heart defects, heart murmur or rheumatic heart disease)?
YES NO Skin disorder?
YES NO Does the patient have a well-balanced diet?
YES NO Frequent headaches, colds or sore throat?
YES NO Eye, ear, nose or thoat condition?
YES NO Hay fever, asthma, sinus trouble or hives?
YES NO Tonsil or adenoid conditions?

Allergies or reactions to any of the following:

YES NO Local anesthetics (Novocain or Lidocaine)
YES NO Aspirin
YES NO Ibuprofen (Motrin, Advil)

YES NO Penicillin or other antibiotics
YES NO Sulfa drugs
YES NO Codeine or narcotics
YES NO Metals (jewelry, clothing snaps)
YES NO Latex (gloves, balloons)
YES NO Vinyl
YES NO Acrylic
YES NO Animals
YES NO Foods (Specify)_____
YES NO Other substances (Specify)_____

Is the patient taking medication, nutrient supplements, herbal medications or non-prescription medicine? Please name them.

Medication_____Taken for_____
Medication_____Taken for_____
Medication_____Taken for_____

Does the patient currently have or ever had a substance abuse problem?
Does the patient chew or smoke tobacco?
Operations? Describe:_____
_____
Hospitalized? For?_____
Other physical problems or symptoms? Describe:_____
Being treated by another health care professional? For?_____
Date of most recent physical exam?_____
Are there any other medical conditions that we should be aware of?_____
_____
Girls Only:
Has the patient started her monthly periods? If so, approximately when?__
_____
Family Medical History:

Do the patients parents or siblings have the following conditions:

YES NO Bleeding
YES NO Severe Allergies
YES NO Jaw Size Imbalance appointment
YES NO Diabetes
YES NO Arthritis
YES NO Unusual dental problems

Any other family medical/dental conditions we should know about?_____
_____

For the following questions mark yes or no. The answers are for office records only and will be considered confidential. A thorough and complete history is vital to a proper dental evaluation.

Dental History

Now or in the past, has the patient had:
YES NO Started teething very early or late?
YES NO Primary (Baby) teeth removed that were not loose?
YES NO Permanent or "extra" (supernumerary) teeth removed?
YES NO Supernumerary (extra) or congenitally missing teeth?
YES NO Chipped or otherwise injured primary (baby) or permanent teeth?
YES NO Teeth sensitive to hot or cold; teeth throb or ache?
YES NO Jaw fractures, cysts or mouth infections?
YES NO "dead teeth" or root canals treated?
YES NO Bleeding gums, bad taste or mouth odor?
YES NO Periodontal "gum problems"?
YES NO Food impaction between teeth?
YES NO Thumb, finger, or sucking habit? Until what age?_____
YES NO Abnormal swallowing habit (tongue thrusting)?
YES NO History of speech problems?
YES NO Mouth breathing habit, snoring or difficulty in breathing?
YES NO Tooth grinding or jaw clenching?
YES NO Any pain in jaw or ringing in ears?
YES NO Any pain or soreness in the muscles of the face or around the ear?
YES NO Difficulty in chewing or jaw opening?
YES NO Aware of loose, broken or missing restorations (fillings)?
YES NO Any teeth irritating cheek, lip, tongue or palate?
YES NO Concerned about spaced, crooked or protruding teeth?
YES NO Aware of concerned about under or over developed jaw?
YES NO "Gum Boils", frequent canker sores or cold sores?
YES NO Taking any forms of fluoride?
YES NO Any relative with similar tooth or jaw relationships?
YES NO Had periodontal (gum) treatment?
YES NO Would the patient object to wearing orthodontic appliances (braces) should they be indicated?
YES NO Had any serious trouble associated with any previous dental treatment?
YES NO Ever had a prior orthodontic examination or treatment?
YES NO Been under another dentist's care?
Specialist_____
Other_____

How often does your child brush?_____
Floss?_____
What is your primary concern?_____
Why is your child here?_____
I have read and understand the above questions, I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes later to this history record or medical/dental status, I will inform this practice.
Signed:_____(Parent or Guardian)

PATIENT CONSENT FORM
(HIPAA)

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

*Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
*Obtaining payment from third party payers (e.g. my insurance company)
The day to day healthcare operations of your practice

I have also been informed of, and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this ____ day of _____, 2019
Print Patient Name: _____
Relationship to Patient: _____
Signature: _____

Hill Country Pediatric Dentistry & Orthodontics
12225 Bee Caves Rd
Bee Cave, TX 78738
512-263-7455

Hill Country Pediatric Dentistry & Orthodontics Financial Policies and Release of Information

Thank you for choosing Hill Country Pediatric Dentistry & Orthodontics for your dental health care. Our main concern is that you receive the proper and optimal treatment needed to restore your health. It's important to remember that your insurance coverage is a contract between your employer and your insurance company. Benefits and coverage vary significantly from plan to plan depending upon what your employer has agreed to with the insurer. Please keep in mind that insurance is not designed to provide 100% benefit, but rather is meant to assist in cost of dental care. As a courtesy to our patients, we are happy to file claims on your behalf. To do this, you must provide us accurate and up to date insurance information. Your estimated out-of-pocket expense is required at the time of service unless prior arrangements have been made. We accept Cash, Check, Debit Cards, Visa, MasterCard, Discover, AMEX, and Care Credit. Once applicable insurance has paid, any remaining balance will be the responsibility of the patient due upon receipt of statement. Our office is committed to helping you maximize your insurance benefits. Because insurance policies vary, we can only estimate your coverage in good faith, but cannot guarantee coverage due to the complexities of insurance contracts. We recommend that all patients contact their insurance company to better understand their benefits and how claims will be processed. We will attempt to help you receive full insurance benefits; however, you are personally responsible for your account, and we encourage you to contact your insurance company if they have not paid within 30 days. Your treatment plan will include a breakdown of all applicable fees, and we will inform you of all cost before treatment is administered. If special arrangements are needed, please talk to our financial manager prior to receiving service. **Missed Appointments**: Your scheduled appointment time has been reserved specifically for you. If you are unable to keep an appointment please **notify us (even after hours) at least 48 hours in advance. Failure to notify us less than 48 hours before your appointment may result in a minimum broken appointment charge of $45.00. Returned Checks:** For checks returned to us, as unpaid by your bank, we will charge you a $35.00 fee.

Patient/Guardian Signature: _____
Date: _____