HillsideDental

Patient Information

Name _____ (☐ Male / ☐ Female) SSN _____ - _____ - _____

Date of Birth (mm/dd/yy) _____/_____/_____ ☐Married ☐Single ☐Divorced ☐Widowed ☐Partner

Address _____ _____ _____ _____
Street City State Zip code

Phone No. Home_____ Cell_____ Work_____

Email_____ May we contact you by email? ☐ Yes ☐ No

Emergency Contact _____ Relation: _____ Phone No._____

How did you hear about us? ☐ Newspaper ☐ Internet ☐ Referral Other:_____

Dental Insurance Information

Subscriber Name_____ Relationship_____

Employer Name_____ Employer Phone_____

Insurance Company_____ Insurance Phone_____

Insurance ID No._____ Insurance Group No._____

Do you have an addition insurance? ☐ Yes ☐ No

Subscriber Name_____ Relationship_____

Employer Name_____ Employer Phone_____

Insurance Company_____ Insurance Phone_____

Insurance ID No._____ Insurance Group No._____

Medical History

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Please answer the following medical history questions as correctly as possible.

Are you currently under the care of a physician? ☐ Yes ☐ No

Physician Name: _____ Phone: _____

Have you ever had or currently have any of the following? Please check all that apply.

Yes	No		Yes	No		Yes	No	
☐	☐	Allergies	☐	☐	Heart Disease	☐	☐	Psychiatric Treatment
☐	☐	Anemia	☐	☐	Heart Murmur	☐	☐	Pregnancy Moth
☐	☐	Arthritis	☐	☐	Hepatitis (☐B / ☐C)	☐	☐	Radiation Therapy
☐	☐	Asthma	☐	☐	High/Lower Blood Pressure	☐	☐	Respiratory Disease
☐	☐	Bleeding Disorder	☐	☐	HIV infection	☐	☐	Rheumatic Fever
☐	☐	Cancer	☐	☐	Joint Replacement	☐	☐	Sinus Problem
☐	☐	Chemotherapy	☐	☐	Kidney Disease	☐	☐	Stomach Problems
☐	☐	Diabetes	☐	☐	Liver Disease	☐	☐	Stroke
☐	☐	Digestive Disorder	☐	☐	Neurological Problems	☐	☐	Thyroid Problems
☐	☐	Epilepsy/Seizures	☐	☐	Organ Transplant	☐	☐	Tuberculosis
☐	☐	Fainting	☐	☐	Osteoporosis	☐	☐	Glaucoma
☐	☐	Pacemaker	☐	☐	Other: _____			

Are you allergic to

☐ Aspirin ☐ Codeine ☐ Latex ☐ Local Anesthetics ☐ Narcotics ☐ Penicillin ☐ Sulfa Drugs ☐ Other

Do you have any conditions that are not listed above that we should know about?

_____

List medications you are currently taking:

_____

List all complications or allergic reactions you have had or have:

_____

Has your doctor told you to take antibiotic medication before dental treatment? ☐ Yes ☐ No

Do you take a bone-building drug, a bisphosphonate, i.e. Fosamax? ☐ Yes ☐ No

Are you nursing? ☐ Yes ☐ No Are you taking oral contraceptives? ☐ Yes ☐ No

_____ _____

Signature of Patient/Parent/Guardian Date

_____ _____

Signature of Dentist After Review Date

Dental History

Have you ever had or currently have any of the following? Please check all that apply.

☐ Abnormal bleeding after dental care
☐ Bad Breath
☐ Bleeding gums
☐ Brushing Frequency:_____
☐ Clenching or grinding
☐ Clicking or popping jaw
☐ Cough up blood
☐ Cold / Canker sores or blisters
☐ Dental Floss Frequency:_____
☐ Disclosing tablets or solution
☐ Dry mouth
☐ Sensitive / sore gums
☐ Food impaction
☐ Frequent snacking
☐ Gag easily
☐ Inter dental stimulations
☐ Jaw pain
☐ Loose or broken fillings / teeth
☐ Mouth breathing
☐ Oral habits, i.e. suck thumb
☐ Pain around ear
☐ Periodontal treatment
☐ Receding gums
☐ Other _____
☐ Sensitive to hot / cold
☐ Sensitive to pressure
☐ Sensitive to sweets
☐ Swelling or lumps in mouth
☐ Texture of tooth brushing _____
☐ Tobacco habit / smoking
☐ Toothaches
☐ Unfavorable dental experience
☐ Unpleasant taste
☐ Water jet device
☐ Fluoride supplements

Any previous dental treatments? ☐ Yes ☐ No if Yes, when & what_____
Chief oral complaint _____
Reason for today's visit _____ Date of last dental visit _____
Additional interest in ☐ Whitening ☐ Implant ☐ Veneers ☐ Crowns ☐ Invisalign ☐ Night guard

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ _____
Signature of Patient/Parent/Guardian Date

Authorization

I authorize the disclosure of information from my treatment records to:
Name of Recipient_____ Relationship_____

I give authorization to disclose the following information:

☐ All treatment information ☐ Specific Date: _____ ~ _____

I understand that I may withdraw or revoke my permission at any time with written words.

_____ _____
Printed Name & Signature of Patient/Parent/Guardian Date

INFORMED CONSENT

1. Dental Examination and Treatment Plan
Texas Law requires that the dentist examine and diagnose all new prior to delegating supervision duties to auxiliaries including hygienist for cleaning. INITIAL_____

2. Changes in Treatment Plan
I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination. For example, root canal therapy may follow routine restorative procedures. I give my permission to the dentist to make any and all changes and additions as necessary, after explaining the reason and obtaining my consent. INITIAL_____

3. Drug and Medications
I understand that antibiotics, analgesics and other medications can cause allergic reactions causing redness and swelling of tissue, pain, itching, vomiting, and or anaphylactic shock. INITIAL_____

4. Periodontal Loss
I understand that periodontal disease is a condition of the gums and bone and it can lead to eventual tooth loss. Alternative treatment plans have been explained to me, including scaling, root planning, medicinal irrigation, and gum surgery replacement and/or extraction. I understand that undertaking any dental procedures may not prevent continued bone loss. I understand that I may require constant maintenance. INITIAL_____

5. Fillings
I understand that care must be exercised in chewing on new fillings especially during the first 24 hours, to avoid breakage. I understand that a more extensive filling that originally diagnosed may be required due to additional decay. I understand that significant sensitivity is a common after effect of a newly placed filling. INITIAL_____

6. Crowns, Bridges and Caps
I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realize the final opportunity to make changes in my new crown, bridge, or cap (including shape, fit, size, and color) will be before cementation. It is also my responsibility to return for permanent cementation within 30 days from tooth preparation. Excessive delays may allow for tooth movement. This may necessitate a remake of the crown, bridge, or cap. I understand there will be additional charges for remakes due to my delaying permanent cementation Endodontic (root canal) may be necessary after or during crown cementation. INITIAL_____

7. Endodontic Treatment (Root Canal)
I realize there is no guarantee that root canal treatment will save my tooth, and that complication can occur from the treatment and that occasionally additional surgical procedures may be necessary following root canal treatment (Apicoectomy). I understand that the tooth may be lost despite all efforts to save it. In some cases, a preciously treated tooth should be restored as soon as possible to protect it from fracture or decay. INITIAL_____

8. Removal of Teeth
Alternative to removal have been explained to me (root canal therapy, crown and periodontal surgery, etc). I understand removing teeth does not always remove all the infection, if present, and it may be necessary to have further treatment. I understand the risks involved in having teeth removed, some of which are pain, swelling, and spread of infection, dry socket, loss of feeling in my teeth, lips tongue and surrounding tissue (paresthesia) that can last for an indefinite period of time or fractured jaw. I understand I may result in poorly fitting dentures. If a remake is required due to my delays of more than 30 days, there will be additional charges. INITIAL_____

9. Dentures
I understand that wearing of dentures is difficult. Sore spots altered speech, and difficulty in eating are common problems. Immediate dentures (placement of denture immediately after extractions) may be painful. Immediate dentures may require considerable adjustment and several relines. A permanent reline will be need later. This is not included in the original denture fee. I understand that it is my responsibility to return for delivery of the dentures. I understand that failure to keep my delivery appointment may result in poorly fitting dentures. If a remake is requires due to my delays of more than 30 days, there will be additional charges. INITIAL_____

10. Cosmetic Services
Cosmetic services may not be covered by insurance plans. This includes porcelain facings on molars, cosmetics bleaching, cosmetic bonding and laminated (veneers). INITIAL_____

11. Optional Treatment (Bone Graft & Sinus Lift)
The need for treatment that is excluded as a benefit by insurance has been explained to me. If I choose to proceed, the use and cost of noble metals including god, will be with my consent. INITIAL_____

I hereby authorize any of the doctors to proceed with and perform the dental restorations and treatments explained to me. I understand that regardless of any dental insurance coverage I may have, I am responsible for payment of dental fees. Should any dispute arise over dental services provided to me, which is whether any dental service rendered was allegedly unnecessary, unauthorized or was improperly, negligently, or incompetently performed said dispute will be submitted to peer review by an appropriate dental society, which will be a component of the American Dental Association. The decision of peer review shall be binding on both parties. I have read, understood and agreed to everything above numbers 1-11.

Signature: X_____ Date: _____

Witness : X_____ Date: _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLAESE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

USES AND DISLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment and health care operations. For example:

Treatment: We may use of disclose your health information to a physician or other healthcare provider providing treatment to you, or to family and friends you approve.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use disclose your health information in connection with your health care operations. Health care operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, and certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment for healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. You also have the right to request restrictions on disclosure of PHI (Personal Health Information), or alternative means of communication to ensure privacy.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law or national security activities.

Abuse or Neglect: We may disclose your health information to appropriate authorities when we suspect abuse or neglect.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

Patient Rights

Access: You have the right to look at or get copies of your health information with limited exceptions. If you request copies, we will charge you a reasonable fee to locate and copy your information and postage if you want the copies mailed to you.

QUESTIONA AND COMPLANTS

If you want more information about our privacy practices or have questions or concerns, please contact us.
If you are concerned that we may have violated your privacy rights, or you disagree with a decisions we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contract information listed at the end of this Notice. You also may submit a written complaint to the U.S. department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.
We support you right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us with the U.S. Department of Health and Human Services.
A Privacy/Contract Officer has been designated for this office. Please ask our front desk personnel and they will direct you to the Privacy/Contract Officer.

PATIENT ACKNOWLEDGMENT OF RECEIP OF NOTICE OF PRIVCY PRACTICES AND CONSENT FOR NECESSARY USE OF PERSONAL HEALTH INFORMATION.

_____ _____

Printed Name & Signature of Patient/Parent/Guardian Date

I,_____, have received a copy of this office's NOTICE OF PRIVACY PRACTICES
(Print Name of Patient)

As required by federal law and I consent to the use and disclosure of my personal health information by your office during Treatment, Billing/Payment and Healthcare Operations as outlined in the Notice of Privacy Practices.

Witness : X_____ Date: _____