HILLCREST DENTAL CARE
*A Beautiful Smile. A Relaxing Visit.*

Michael T. Thrasher, DDS
7124 Woodway Dr. Waco, TX 76712 (254)753-0313 Fax (254)753-0315

**Patient Information:**

E-mail Address: _____

Last Name: _____First Name: _____ M.I.: _____

Preferred Name: _____DOB: _____ Sex: M or F SSN: _____

Address: _____City, State, Zip: _____

Driver's License/State/Expiration: _____

Cell: _____ Work: _____Home: _____

Employer: _____ Occupation: _____

Employer Address, City, State, Zip:

_____

Emergency Contact: _____Phone#:_____

Spouse's Name: _____ Occupation: _____

Employer:

_____

Please indicate best Phone # to contact during business hours: _____

Preference of appointment confirmation contact (please circle): Home Cell Work E-mail Text

## Acknowledgement of Receipt of Notice of Privacy Practices

This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement. *You may refuse to sign this acknowledgement*

I, _____, have received a copy/explanation of this office's Notice of Privacy Practices.

_____ _____

(Signature of Patient and/or Guardian) (Date)

***For Office Use Only***

*We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:*

__ *Individual refused to sign*

__ *Communications barriers (language) prohibited obtaining the acknowledgement*

__ *An emergency situation prevented us from obtaining acknowledgement at time of service*

__ *Other (Please specify)* _____

**HIPAA Privacy Consent:**

I hereby authorize Hillcrest Dental Care to take the necessary x-rays, study models, photographs or any other diagnostic aids deemed appropriate to make a thorough diagnosis of the patient's dental needs. I also authorize Hillcrest Dental Care to perform all forms of treatment, medication, and therapy that may be indicated. I understand the use of anesthetic agents embodies a certain risk. I understand that my dental insurance is a contract between me and the insurance carrier and not between Hillcrest Dental Care and my insurance company. I fully understand that it is my responsibility only for all dental treatment regardless of insurance coverage.

Patient/Guardian Signature: _____ Date: _____

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**Insurance Information**:
Primary Insurance Company: _____
Address/City/State/Zip: _____
Phone #: _____ Member ID: _____ Group #: _____
Subscriber: _____ Date of Birth: _____ SSN: _____
Secondary Insurance Company: _____
Address/City/State/Zip: _____
Phone #: _____ Member ID: _____ Group #: _____
Subscriber: _____ Date of Birth: _____ SSN: _____

I hereby authorize the release of any information to my insurance company or companies, including records of examinations, diagnosis and/or treatment. This release is solely for facilitating the billing and reimbursement, directly to Hillcrest Dental Care of insurance benefits under which I am entitled. I hereby agree that I am financially responsible for all treatment rendered, and understand that the financial policies of the practice will be reviewed with me.

Patient/Guardian Signature: _____ Date: _____

## Our Financial Philosophy

It is important to us that the quality of our business services match the quality of our dental care. We want the handling of your account, from the start to be perceived as an extension of the dental care we provide you and your family.

Patient's Role

As with any partnership, both parties have a role to play. Our role is to provide you with quality service. In turn, your role is to pay for your treatment at time of services. Our team will work with you to determine financial arrangements that make sense for both of us. With an agreement made, our joint follow-through will result in a win for everyone. So that we may file your insurance claim(s) correctly, we ask all patients to complete our Information and Insurance Form before seeing the doctor as that insures our office of obtaining the correct information to better serve you in regards to your benefit**s**.

> Regarding Insurance: We file insurance claims for all patients with dental insurance benefits. We accept assignment of insurance benefits, however the balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you give us your complete insurance information. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. If your insurance company has not paid on your claim within 45 days, the full balance will automatically be transferred to you. That balance will be due upon billing.

We accept CASH, CHECKS, MASTERCARD, VISA, AMERICAN EXPRESS, AND DISCOVER. Ask us about 0% financing.

I understand that if my account reaches collection status (90 days) and I make no effort to pay, that my account will be assigned to a collection attorney or agency. If Hillcrest Dental Care must take additional steps to collect my account balance, I will pay ALL cost of collection, including court cost and attorney's fees incurred by Hillcrest Dental Care. I give consent for any credit check to be completed by Hillcrest Dental Care should it be deemed necessary.

I have read, understand, accept, and agree to this Financial Policy.

Patient/Guardian Signature: _____ Date: _____

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**Dental Health History:**

Name of Former Dentist: _____

How long since you were last seen? _____

Is keeping your teeth important to you? [Y] [N] If yes, why? _____

_____

Have you ever experienced any of the following problems:

[Y] [N] Bleeding gums?

[Y] [N] Bad breath or sour taste in mouth?

[Y] [N] Burning sensations in mouth?

[Y] [N] Soreness in jaw?

[Y] [N] Is it hard for you to open wide?

[Y] [N] Clicking or popping in jaw?

[Y] [N] Have you or your parents suffer(ed) from Gum Disease?

[Y] [N] Did you ever wear braces?

[Y] [N] Oral Surgery of any kind?

[Y] [N] Sensitivity to Hot or Cold?

[Y] [N] Snoring?

[Y] [N] Food catching between teeth?

[Y] [N] Clenching or Grinding of teeth?

[Y] [N] Pain/soreness around ears, eyes, face?

[Y] [N] Stiff neck muscles?

[Y] [N] Do you or your parents wear dentures/partials?

[Y] [N] Ever been injured in your mouth or head?

[Y] [N] Do you smoke or chew tobacco?

Does having dental treatment make you afraid or nervous? [Y] [N] If yes, what specific things bother you? _____

Is there anything you wish to change about your smile? _____

_____

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How did you hear about us?

In an effort to ensure that we are reaching our patients in as many ways as possible, will you please mark ALL that apply:

- ___ Patient referral, Patient's name: _____
- ___ Professional referral, Provider's name: _____
- ___ Staff referral, staff's name: _____
- ___ AT&T yellow pages
- ___ TV, KWTX Channel 10
- ___ TV, KXXV Channel 25
- ___ Infomercial, KWTX Channel 10
- ___ Infomercial, KXXV Channel 25
- ___ Texas Living Magazine
- ___ Wacoan Magazine
- ___ Website: SedationDentistWaco.com, Google, Yelp, Other? _____
- ___ Word of Mouth
- ___ Returning Patient
- ___ Location, LED sign, walk-in
- ___ Facebook
- ___ YouTube
- ___ Other

Patient/Guardian signature: _____

Date: _____

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**Health History:**

Are you in good health? [Y] [N] Has there been a change in your health within the last year? Explain:

_____

Have you been hospitalized or had a serious illness in the last 5 years? Explain: _____

_____

Are you being treated by a physician now? [Y] [N] For what? _____

_____

Name of your physician: _____ Last medical exam: _____

**Have you ever experienced**:

[Y] [N] Chest pains
[Y] [N] Swollen ankles
[Y] [N] Shortness of breath
[Y] [N] Recent weight loss/fever/night sweats
[Y] [N] Persistent cough/coughing up blood
[Y] [N] Bleeding problems/bruising easily
[Y] [N] Sinus Problems
[Y] [N] Difficulty swallowing
[Y] [N] Joint pain/stiffness
[Y] [N] Jaundice
[Y] [N] Dizziness
[Y] [N] Ringing in ears
[Y] [N] Frequent headaches/migraines
[Y] [N] Fainting spells
[Y] [N] Blurred vision
[Y] [N] Seizures
[Y] [N] Excessive thirst
[Y] [N] Frequent urination
[Y] [N] Dry mouth
[Y] [N] Sleep apnea/chronic snoring

**Do you have or have you ever had**:

[Y] [N] Heart disease
[Y] [N] Heart attack/heart defects
[Y] [N] Heart murmur
[Y] [N] Rheumatic fever
[Y] [N] Stroke/hardening of arteries
[Y] [N] High blood pressure
[Y] [N] TB/emphysema/other lung disease
[Y] [N] Hepatitis A B C
[Y] [N] Stomach problems/ulcers
[Y] [N] Diabetes
[Y] [N] Mitral valve prolapse
[Y] [N] Contact lenses
[Y] [N] HIV positive/AIDS-ARC
[Y] [N] Tumors/Cancer
[Y] [N] Arthritis/rheumatism
[Y] [N] Eye disease
[Y] [N] Skin disease
[Y] [N] Anemia
[Y] [N] VD (syphilis or gonorrhea)
[Y] [N] Herpes
[Y] [N] Kidney/bladder diseases ]
[Y] [N] Thyroid/adrenal diseases
[Y] [N] Family history of diabetes/heart problems/cancer

**Do you have or have you had:**

[Y] [N] Radiation treatments
[Y] [N] Prosthetic heart valve
[Y] [N] Currently taking birth control pills
[Y] [N] Chemotherapy
[Y] [N] Pacemaker
[Y] [N] Pregnant or nursing

List surgeries: _____

Blood Transfusions: _____

Artificial Joint: _____

Psychiatric Care: _____

**List Vitamins/Medications**: _____

_____

Do you take or have taken:

[Y] [N] Recreational drugs [Y] [N] Alcohol [Y] [N] Tobacco
[Y] [N] Phen Phen or other diet pills [Y] [N] Fosamax/Boniva or other Bisphosphonate drugs

Allergies: Latex, any drugs, foods, medications, metals, jewelry, acrylic, etc., please list:

_____

Do you have any other diseases/medical problems NOT listed? If yes, please explain:

_____

Have you been told that you need to pre-medicate (antibiotics) prior to dental treatment? [Y] [N]
Are you currently using a CPAP machine? [Y] [N]