It's good to know you!

Thanks for taking a few moments to tell us about yourself so we can better serve you. Also, please let us know whom we may thank for referring you to our practice: _____

HILL COUNTRY DENTAL ASSOCIATES

Patient Information:

Patient is (please check all that apply): ○ Responsible Party ○ Policy Holder			
First Name:	Last Name:		Middle Initial:
Preferred Name:			
Address:			
City, State Zip:			
Phone Numbers: Home:		Work:	Cell:
Email Address:			○ Ok to send text messages
Sex: ○ Male ○ Female	Birth Date:		Age:
Social Security Number:		Driver's License Number:	
Marital Status: ○ Single ○ Married ○ Divorced ○ Separated ○ Widowed			
Employment Status: ○ Full-Time ○ Part-Time ○ Retired			
Student Status: ○ Full-Time ○ Part-Time			

Responsible Party Information *(If someone other than the patient):*

○ Responsible Party is also a Policy Holder for the Patient			
First Name:	Last Name:		Middle Initial:
Address:			
City, State Zip:			
Phone Numbers: Home:		Work:	Cell:
Email Address:			○ Ok to send text messages
Sex: ○ Male ○ Female	Birth Date:		Age:
If Patient is a minor, please indicate parents' names:	Mom:	Dad:	

How would you prefer to be contacted?

Our communication system allows us to interact you through electronic courtesy appointment reminders, office newsletters, and more! With your permission, we'll reach out to you on your home or cell phone (text messaging rates may apply), and/or by email. Please take a moment to let us know how you would like to be contacted and how frequently.

Yes! Please reach out to me through (check all that apply): ○ text messaging ○ email ○ home phone

Please send courtesy appointment reminders (check all that apply):

○ 2 weeks in advance ○ 2 days in advance ○ 2 hours in advance

Thanks, but no thanks--I prefer not to be included. ○

Please continue on the following page. →

Insurance Information *(We are happy to file claims for your primary insurance policy.)*

Name of Insured Policy Holder:	
Patient's Relationship to Policy Holder: ○Self ○Spouse ○Child ○Other	
Policy Holder's Social Security Number:	Birth Date:
Employer:	Ins. Company:
Address:	Address:
City, State Zip:	City, State, Zip:

Authorization for Submission of Claims and Assignment of Benefits

I authorize Hill Country Dental Associates (HCDA) to submit claims for payment for services rendered on my behalf and in my name to health care service plans or insurance companies named, and to assign to HCDA the insurance benefits otherwise payable to me, but not to exceed the provider's actual charges for the covered services. I understand that I am financially responsible for any charges not covered by the insurance benefits.

Name of Patient:_____ Date:_____

Signature of Patient, Parent, or Guardian:_____

Authorization for Release of Health Information

I authorize Hill Country Dental Associates (HCDA) to release any and all information and records (including x-rays) about my medical/dental history, or about services rendered or treatment provided to me, to health care service plans, insurance companies, self-insurers, or their representatives, when such information is needed to review, investigate, or evaluate any claim for benefits.

If my benefit coverage is under a group master agreement held by my employer, an association, trust fund, union, or similar entity, this authorization also permits disclosure to them for purposes of utilization review or financial audit.

Name of Patient:_____ Date:_____

Signature of Patient, Parent, or Guardian:_____

Acknowledgement of Reciept of Notice of Privacy Practices

I acknowledge that I have received a copy of the "Notice of Privacy Practices" for Hill Country Dental Associates.

Name of Patient:_____ Date:_____

Signature of Patient, Parent, or Guardian:_____

Consent for Treatment

1. I hereby authorize the doctor or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of (name of patient)_____'s dental needs.

2. Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

3. I consent to the use of appropriate medication and therapy as deemed necessary. I fully understand that using anesthetic agents embodies certain risk.

4. I agree to be responsible for payment of all services rendered on my behalf or for my dependents. I understand that payment is due at the time of service unless other arrangements have been made. I further understand that I am responsible to pay reasonable attorney's fees and costs of collection in the event of default.

Patient: _____ Date:_____ Witness:_____

Parent/Responsible Party:_____ Relationship to Patient:_____