HEDGECOCK
DENTAL

MODERN | NATURE-INSPIRED | FAMILY & COSMETIC DENTISTRY

Welcome!

We are delighted that you have chosen Hedgecock Dental!

What a difference when you walk through the front door…you will find a comfortable reception area, enjoyable atmosphere, as well as friendly staff members attentive to each individual's needs and well-being. State of the art equipment and sterilization techniques provide service of the highest quality. So, please let us know of anything we can do to make your visit as pleasant an experience as possible.

Please download the New Patient Information, Medical / Dental History, and HIPAA Forms from this website. Bring the completed forms, health related and insurance information, insurance card, as well as photo ID with you to your appointment. Your appointment time is especially reserved for you, so we do request forty-eight hours, notice, if a schedule conflict arises.

Hedgecock Dental is easy to locate at 5704 Highway 290 West, and we have plenty of accessible parking. You will find a map on the New Patient page of www.hedgecockdental.com.

Again, we are pleased to have you as a new patient and look forward to meeting you. If you have any questions or need help with anything, please feel free to give us a call 512-892-CARE (2273).

Sincerely,

Michelle Hedgecock DDS Brandon Hedgecock D.DS.

Drs. Brandon and Michelle Hedgecock, DDS

HEDGECOCK
DENTAL

PATIENT INFORMATION FORM

(Please Print)

Today's date:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid
Is this your legal name? ❑ Yes ❑ No	Preferred Name:	Social Security # :	Birth date: / /	Age:	Sex: ❑ M ❑ F
E-mail address:		Cell phone # : ( )		Home phone # : ( )	
Street address		City:	State, Zip:	How long at this address :	
Occupation:	Employer/Years Employed:			Employer phone #: ( )	
Who were you referred by (please check one box):		❑ Dr.		❑ Insurance Plan	❑ Hospital
❑ Family	❑ Friend	❑ Close to home/work	❑ Online	❑ Other	
Other family members seen here:					

RESPONSIBLE PARTY & INSURANCE INFORMATION

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone #: ( )	
Relationship to patient:	❑ Mother	❑ Father	❑ Sibling	❑ Guardian ❑ Other:
Is this person a patient here?	❑ Yes	❑ No		
Occupation:	Employer:	Employer address:	Employer phone #: ( )	
Is this patient covered by insurance?	❑ Yes	❑ No		
Please indicate name of primary insurance company:				
Subscriber's name:	Subscriber's S.S.N.	Birth date: / /	Group #:	Policy #:
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other
Name of secondary insurance (if applicable):	Subscriber's name:	Group #:	Policy #:	
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone : ( )	Work phone : ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Hedgecock Dental or insurance company to release any information required to process my claims. I understand that where appropriate, credit bureau reports may be obtained.

_______________________________ *Patient/Guardian signature*

_______________ *Date*

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Medical History

Patient's Name: ____ Date of Birth**:** _____________ Today's Date: _____________

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health Problem that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive.

Are you under a physician's care now? ☐ No ☐ Yes

If yes, please provide physician's name and number: ____

Have you ever been hospitalized or had a major operation? ☐ No ☐ Yes

If yes, please explain:____

Have you ever had a serious head, neck or back injury? ☐ No ☐ Yes

If yes, please explain: ____

Are you taking any medications, pills or drugs? ☐ No ☐ Yes

If yes, please list: ____

Do you take, or have you taken Phen-Fen or Redux? ☐ No ☐ Yes

Are you on a special diet? ☐ No ☐ Yes ____

Do you use tobacco? ☐ No ☐Yes If yes, please list amount and frequency: ____

Do you use controlled substances? ☐ No ☐ Yes If yes, explain: ____

Women: Are you ☐ Pregnant ☐ Trying to get pregnant ☐ Nursing ☐ Taking oral contraceptives

Are you allergic to any of the following? ☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Barbiturates ☐ Latex ☐ Metal ☐ Iodine ☐ Dental Anesthetics ☐ Acrylic ☐ Tetracycline ☐ Erythromycin

Please list any other allergies: ____

Do you have, or have you had, any of the following?

___AIDS/HIV
___Anaphylaxis
__Arthritis/Rheumatism
___Artificial Joints *
___Cold Sores/Fever Blisters
___Convulsions
___Cortisone Injections
___Epilepsy/Seizures
___Excessive Thirst
___Fainting spells/Dizziness
___Frequent cough
___Frequent headaches
___Frequent Diarrhea
___Gastrointestinal disorders
___Glaucoma
___High Blood Pressure
___Hives or Rash
___Liver Disease/Jaundice
___Low Blood Pressure
___Metal pins, plates, screws
___Pain in jaw joints
___Parathyroid Disease
___Recreational Drug Use
___Renal Dialysis*
___Rheumatic Fever*
___Scarlet Fever
___Sexually Transmitted Disease

___Shingles
___Sinus Trouble
___Stents
___Stroke
___Swelling of Limbs
___Thyroid Disease
___Tonsillitis
___Tumors or growths
___Ulcers

Heart Complications:

___Angina
___Artificial Heart Valve*
___Chest Pains
___Congenital Heart Disorder
___Congenital Heart Failure
___Heart Attack/Heart Failure
___Heart Disease
___Heart Pacemaker
___Heart Murmur
___Irregular Heartbeat/Arrhythmia
___Mitral Valve Prolapse

Lung Complications:

___Asthma
___Emphysema
___Easily Winded
___Lung Disease
___Tuberculosis

Cancer (type) ________________

___Chemotherapy
___Radiation Therapy
___Blood Disorders:
___Blood Disease
___Blood Transfusion
___Diabetes (type) I or II
___Excessive bleeding
___Hemophilia
___Hepatitis A
___Hepatitis B or C
___Hypoglycemia
___Leukemia
___Anemia

Mental Health Disorders:

___ADD/ADHD
___Alzheimer's Disease
___Anorexia or Bulimia
___Anxiety
___Autism
___Bipolar Disorder
___Depression
___Developmental Disorders
___Mania
___Mental Illness/Retardation
___Schizophrenia

*** Conditions that may require pre-medication.**

Are you currently or have you ever taken one of the following medications for the treatment of Osteoporosis? Yes/No

Circle all that apply: Actonel Bonvia Fosamax or Fosamax Plus D Skelid Didronel

Have you ever been administered any of the following drugs intravenously (IV) for the treatment of Cancer? Yes/No

Circle all that apply: Aredia Zometa Benefos

Why have you come to the dentist today? ____

Are you currently in pain? □ Y □ N

Have you ever had a serious or difficult problem with dental treatment? □ Y □ N Have you ever had gum treatment? □ Y □ N

Do you now or have you ever experienced pain / discomfort in your jaw joint? (TMJ / TMD) □ Y □ N

Do you like your smile? □ Y □ N Do your gums ever bleed? □ Y □ N Do you have wisdom teeth? □ Y □ N

How many times a day do you brush? __________ Floss? _____ Do you use any other cleaning aids? __________________

Are your teeth sensitive to heat, cold, chewing or anything else? ____

Have you had any of the following in the past or present? □ Crowns □ Root Canals □ Implants

Previous Dentist: ____ Date of last visit: _________________________

Initial the following Terms of Agreement:

_______I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

_______I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such dental care to Third Party Payer and / or health practitioners.

_______I authorize and hereby expressly request my insurance company to pay directly to Hedgecock Dental, PLLC all insurance benefits otherwise payable to me.

_______I understand that due to the severe restrictions placed by my insurance company on the level of benefits in the policy purchased by me or my employer, my dental insurance carrier may pay less than the actual bill for services. This office will attempt to obtain benefits in patient's behalf for 90 days post treatment. Hedgecock Dental, PLLC is not responsible for changes in insurance policy benefits, utilization fees, restrictions and yearly maximums. I agree to be responsible for payment of all services rendered on my behalf or on the behalf of my dependents. I understand that dental insurance does not work like medical insurance. Benefits are basic and minimal.

_______I understand that cancellation or appointment changes less than 24 hours will result in a $25 charge.

Thank you for filling out this form completely. The information you have provided will help us to provide your dental health care more effectively and efficiently. If you have any questions, please ask us. We are happy to help.

Signature:____ 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.

**PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.**

OUR LEGAL DUTY
We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 14, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice, at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION
We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

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

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

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

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.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

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. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $1.00 for each page, $15.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS – If you want more information about 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 decision 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 contact information listed at the 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 your right to privacy of you health information. We will not retaliate in anyway if you choose to file a complaint with us with the U.S. Department of Health and Human Services.

Contact Officer: Business Administrator   Email contact: info@hedgecockdental.com

Telephone: (512)892-2273   Fax: (512)892-2217

Address: 5704 Highway 290 West, Austin, Texas 78735

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HEDGECOCK
DENTAL

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Printed Name: ____

SECTION B: TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our 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:

Contact Person: Business Administrator   Email contact: info@hedgecockdental.com

Address: 5704 Highway 290 West, Austin, Texas 78735

Telephone: (512)892-2273   Fax: (512)892-2217

SIGNATURE

I, ____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and heath care operations.

Signature: ____   Date: ______________________

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: ___________________________________Relationship to Patient: ______________

REVOCATION OF CONSENT

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 we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will *not* affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: ____   Date: ______________________________

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT