HIGHLAND HILLS DENTAL CENTER

3402 S. Gevers San Antonio, Texas 78210
210-533-6611 Fax 210-533-6757

PLEASE FILL OUT THIS FORM AS COMPLETELY AS POSSIBLE

PATIENT INFORMATION (CONFIDENTIAL)

DATE: _____

NAME_____BIRTHDATE_____

MAILING ADDRESS_____

CITY_____STATE_____ZIP_____ SS#_____

HOME PHONE_____CELL PHONE_____WORK PHONE_____

E-MAIL ADDRESS_____ **PREFERRED METHOD TO BE CONTACTED**_____

CHECK APPROPRIATE BOX: ☐ MINOR ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ SEPARATED

PATIENT'S EMPLOYER/ SCHOOL_____ ☐ FULL TIME ☐ PART TIME

SPOUSE/PARENT'S NAME_____PHONE_____

EMERGENCY CONTACT_____PHONE_____

How did you hear about our office? (Family, Friend, Neighborhood, Google, Insurance List), _____

PRIMARY CARE PHYSICIAN_____PHONE_____LAST PHYSICAL_____

RESPONSIBLE PARTY

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT_____

RELATIONSHIP TO PATIENT_____HOME PHONE_____

ADDRESS_____

DRIVER'S LICENSE #_____BIRTHDATE_____SS#_____

EMPLOYER_____WORK PHONE_____

IS THE RESPONSIBLE PARTY CURRENTLY A PATIENT WITH OUR OFFICE? ☐ YES ☐ NO

DENTAL INSURANCE INFORMATION

NAME OF INSURED_____RELATIONSHIP TO PATIENT_____

BIRTHDATE_____SS#_____DATE EMPLOYED_____

NAME OF EMPLOYER_____WORK PHONE_____

EMPLOYER ADDRESS_____CITY_____STATE_____ZIP_____

INSURANCE COMPANY_____PHONE_____

INSURANCE CO. ADDRESS_____CITY_____STATE_____ZIP_____

POLICY/ID #_____GROUP #_____

DO YOU HAVE ANY ADDITIONAL DENTAL INSURANCE? ☐ YES ☐ NO

HIGHLAND HILLS
DENTAL CENTER

Highland Hills Dental Center Mission Statement

To provide professional dental services by delivering a consistent, patient centered and cost conscious care experience by friendly, attentive and professional team members.

Office Policy

Thank you for entrusting us with your dental needs, we look forward to providing you with the best dental care at an affordable cost. Dental treatment is an excellent investment in an individual's medical and psychological well-being. We understand that every person's financial situation is different. For this reason, we have made available a variety of payment options to help you receive the dental care you need and deserve and that allows you to enjoy a healthy and beautiful smile that suits your budget.

Payment Policy:

- All treatment will require a deposit to schedule an appointment.
- Cash, Check, *MasterCard, Visa, Discover,* and *American Express* are accepted.
- Flexible Payment Options are available with approved credit through **Care Credit** and **Lending Tree.**
- We offer up to a 10% accounting courtesy for all *restorative services* over $500 paid in full (cash or check) upon scheduling.
- Major Services- We offer a two-payment option for *Crown, Bridge,* and *Denture* treatment.

Insurance Policy:

We are contracted with most PPO dental plans. *Please ask the front office if we are in your preferred network.* Our goal is to help you get the most benefit out of your particular policy. We will file your claims for you on your behalf and answer any questions we can for you. Please note that all **Co-payments** and **Deductibles** are due at the time services are rendered, unless financial arrangements are made prior to your dental appointment. Also, keep in mind that you are ultimately responsible for any balance left unpaid by your dental insurance.

Cancellation Policy:

Our doctors and hygienists strive to render excellent dental care to you and the rest of our patients and we understand that unplanned *emergencies* can come up and you may need to cancel an appointment. If that happens, we respectfully ask for 24 hours advance notice; this allows for other patients an opportunity to be scheduled. There is a $50 charge for **no-show appointments**, and those appointments **not cancelled within 48 hours.** ***Appointments scheduled for 2 or more hours require 72 hour notice.*** *We call 2 days ahead to confirm appointments as a courtesy.* **I agree to give an appropriate amount of time should I need to make changes to my appointment. Signature: _____**

Initials_____

Informed Consent for X-rays & Photographs:

I understand that x-rays, photographs, and other records may be made during the course of my examination, treatment and follow-up care. I give permission for these services to be rendered.

Minors:

Minors are required to have a parent or guardian in the office during the entire duration of the appointment. Minors will not be seen if a parent or guardian is not present. Minor is anyone under the age of 18.

Release of Dental Records Policy:

I authorize **Highland Hills Dental Center** to release my dental records to my insurance company upon request, including, but not limited to periodontal charting, radiographs, and diagnostic photos. **HHDC** may also share your dental record with other dentists that we may consult with on your behalf or with dentists that we refer you to.

Receipts and Account Reports:

We will always give our patients an itemized receipt of their visit, including those with a Health Savings Account. We are not responsible for emailing or faxing these receipts to your HSA Company. If you do require additional reports after we have given you a receipt, we will require 48 hours to get these reports back to you.

Returned Check:

A $35.00 fee will be accessed for return checks. Delinquent accounts may incur a collection fee.

Acknowledgement:

I hereby acknowledge and agree to the above office policies.

Patient or Responsible Party Signature: _____

Patient Name: _____

Date: _____

Time 10:30 AM | Highland Hills Dental Center | Date 2/21/2019

Eaglesoft Medical History

Patient Name: | Birth Date: | Date Created:

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

Are you under a physician's care now?	○ Yes ○ No	If yes
Have you ever been hospitalized or had a major operation?	○ Yes ○ No	If yes
Have you ever had a serious head or neck injury?	○ Yes ○ No	If yes
Are you taking any medications, pills, or drugs?	○ Yes ○ No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	○ Yes ○ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	○ Yes ○ No	If yes
Are you on a special diet?	○ Yes ○ No	
Do you use tobacco?	○ Yes ○ No	

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic
☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Other?	☐	If yes
Do you use controlled substances?	○ Yes ○ No	If yes

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

AIDS/HIV Positive ○ Yes ○ No	Cortisone Medicine ○ Yes ○ No	Hemophilia ○ Yes ○ No	Radiation Treatments ○ Yes ○ No
Alzheimer's Disease ○ Yes ○ No	Diabetes ○ Yes ○ No	Hepatitis A ○ Yes ○ No	Recent Weight Loss ○ Yes ○ No
Anaphylaxis ○ Yes ○ No	Drug Addiction ○ Yes ○ No	Hepatitis B or C ○ Yes ○ No	Renal Dialysis ○ Yes ○ No
Anemia ○ Yes ○ No	Easily Winded ○ Yes ○ No	Herpes ○ Yes ○ No	Rheumatic Fever ○ Yes ○ No
Angina ○ Yes ○ No	Emphysema ○ Yes ○ No	High Blood Pressure ○ Yes ○ No	Rheumatism ○ Yes ○ No
Arthritis/Gout ○ Yes ○ No	Epilepsy or Seizures ○ Yes ○ No	High Cholesterol ○ Yes ○ No	Scarlet Fever ○ Yes ○ No
Artificial Heart Valve ○ Yes ○ No	Excessive Bleeding ○ Yes ○ No	Hives or Rash ○ Yes ○ No	Shingles ○ Yes ○ No
Artificial Joint ○ Yes ○ No	Excessive Thirst ○ Yes ○ No	Hypoglycemia ○ Yes ○ No	Sickle Cell Disease ○ Yes ○ No
Asthma ○ Yes ○ No	Fainting Spells/Dizziness ○ Yes ○ No	Irregular Heartbeat ○ Yes ○ No	Sinus Trouble ○ Yes ○ No
Blood Disease ○ Yes ○ No	Frequent Cough ○ Yes ○ No	Kidney Problems ○ Yes ○ No	Spina Bifida ○ Yes ○ No
Blood Transfusion ○ Yes ○ No	Frequent Diarrhea ○ Yes ○ No	Leukemia ○ Yes ○ No	Stomach/Intestinal Disease ○ Yes ○ No
Breathing Problems ○ Yes ○ No	Frequent Headaches ○ Yes ○ No	Liver Disease ○ Yes ○ No	Stroke ○ Yes ○ No
Bruise Easily ○ Yes ○ No	Genital Herpes ○ Yes ○ No	Low Blood Pressure ○ Yes ○ No	Swelling of Limbs ○ Yes ○ No
Cancer ○ Yes ○ No	Glaucoma ○ Yes ○ No	Lung Disease ○ Yes ○ No	Thyroid Disease ○ Yes ○ No
Chemotherapy ○ Yes ○ No	Hay Fever ○ Yes ○ No	Mitral Valve Prolapse ○ Yes ○ No	Tonsillitis ○ Yes ○ No
Chest Pains ○ Yes ○ No	Heart Attack/Failure ○ Yes ○ No	Osteoporosis ○ Yes ○ No	Tuberculosis ○ Yes ○ No
Cold Sores/Fever Blisters ○ Yes ○ No	Heart Murmur ○ Yes ○ No	Pain in Jaw Joints ○ Yes ○ No	Tumors or Growths ○ Yes ○ No
Congenital Heart Disorder ○ Yes ○ No	Heart Pacemaker ○ Yes ○ No	Parathyroid Disease ○ Yes ○ No	Ulcers ○ Yes ○ No
Convulsions ○ Yes ○ No	Heart Trouble/Disease ○ Yes ○ No	Psychiatric Care ○ Yes ○ No	Venereal Disease ○ Yes ○ No
			Yellow Jaundice ○ Yes ○ No

Have you ever had any serious illness not listed ○ Yes ○ No If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X Date:_____

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DENTAL CENTER

Appointment Confirmations

Thank you for selecting Highland Hills Dental Center. To minimize miscommunication, we request that all patients please read the following regarding Smile reminder confirmation of appointments.

Weekly Reminder
TWO WEEKS before your appointment, you will receive a text message on your phone or an email reminding you about your appointment. You do not need to respond to this text or email.

Daily Confirmation
TWO DAYS before your appointment, you will receive a text message on your phone or an email reminding you about your appointment. Please reply **YES** to your text message or **CONFIRM** to your email

Hourly Confirmation
4 HOURS before your appointment, you will receive a text message on your phone or an email reminding about your appointment.

If you need to **RESCHEDULE** your appointment, **DO NOT** reply to the text message with **NO** or **CANCEL**. It does not come to the receptionist; therefore, your appointment is still on our schedule. Please call the office to reschedule your appointment. **If you fail to call at least 48 hours prior to the appointment, a $50 cancellation fee will be charged.** If you call on a weekend, our answering services cannot cancel Monday's appointment, you must call the Friday before your appointment.

I understand and agree to the above

_____ _____
Signature of Patient or Responsible Party Date

Phone Number to call for Appointment Reminders:

Home # _____ Cell # _____ Work # _____

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Dental History

Patient Name: _____ Date: _____

1. Reason for visit: _____
2. Are you in any pain? Yes No
3. Do you have any concerns about previous dental care or this dental visit?

   _____
4. Previous Dentist _____ Last Visit _____
5. How often do you brush your teeth? _____ Floss?_____
6. Do you have bleeding gums? Yes No
7. Are your teeth loose? Yes No
8. Have you ever been told you have gum disease? Yes No
9. Have you ever been told you have bad breath? Yes No
10. Are your teeth sensitive to: Hot Cold Heat Pressure
11. Have you ever had any pain in your jaw joints? Yes No
12. Do you clench or grind your teeth? Yes No Not Sure
13. Do you require antibiotics prior to dental treatment? Yes No Not Sure
14. Are you happy with your smile? Yes No

Sleep Questionnaire

1. Do you breathe mainly through your nose, mouth or both? _____
2. Do you have frequent headaches? Yes No
3. Do you snore? Yes No
4. Do you wake rested or tired? _____
5. Do you feel excessively sleepy during waking hours? Yes No
6. Have you ever had a sleep study? Yes No
7. Are you currently being treated for sleep apnea? Yes No

   If so, how? _____

Patient Signature: _____ Date: _____

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DENTAL CENTER

WHAT ASPECTS OF YOUR SMILE WOULD YOU LIKE TO IMPROVE?

____ CROWDING/CROOKED TEETH

____ SPACES

____ TOOTH SHAPE

____ TOOTH SIZE

____ GUMMY SMILE

____ UNDERBITE (Deep bite)

____ TEETH ARE DIFFERENT COLORS

____ OTHER _____

____ UGLY OLD CROWNS

____ MISSING TEETH

____ DARK TEETH

____ OVERBITE (Top teeth too far in front of lower teeth)

I AM INTERESTED IN:

____ BRACES

____ TEETH WHITENING

____VENEERS

____ OTHER _____

IS THERE ANYTHING YOU WOULD LIKE DR. ESCARSEGA TO KNOW?

_____

_____

_____

_____

_____

HIGHLAND HILLS
DENTAL CENTER

SIGNATURE RELEASE STATEMENT

YOUR SIGNATURE IS NECESSARY FOR US TO:

1. PROCESS ALL INSURANCE CLAIMS
2. ENSURE PAYMENT FOR SERVICES PROVIDED
3. RELEASE MEDICAL INFORMATION TO INSURANCE COMPANIES NEEDED FOR THE PROCESSING OF YOUR CLAIMS
4. RELEASE INFORMATION TO OTHER MEDICAL AND DENTAL PROVIDERS, INCLUDING LABORATORIES, WHEN NECESSARY, FOR YOUR TREATMENT

I hereby authorize the release of all medical information necessary to process my claims and I authorize release of this same information, when necessary, to other providers rendering medical/dental care, as well as to labs that need my information to make a diagnosis or fabricate an appliance necessary for my treatment.

I assign all medical and surgical benefits, including major medical benefits to which I am entitled, to Dr. Samuel Escarsega DDS /Highland Hills Dental Center. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

Patient Signature _____

Patient Full Name (printed) _____

Guardian Signature (if minor) _____

Witness _____

Date Signed _____

Highland Hills Dental Center
3402 S. Gevers St.
San Antonio, TX 78210
www.highlandhillsdentalcenter.com
Privacy Officer Phone: 210-616-2030
Privacy Officer Email: admin@hcr-audit.com

Notice of Privacy Practices Acknowledgement

I acknowledge receiving the practice's "Notice of Privacy Practices" dated 1/10/2020.

_____ _____ _____
Patient Name **Signature** **Date**

I allow the following persons to have access to my dental records:

_____ _____

_____ _____

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
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (please specify):

_____
_____
_____