# Hedgecock Dental, PLLC

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5920 W. William Cannon Dr. | Bldg. 6 Suite 200 • Austin, TX 78749 (512)892-2273

## Welcome to our Practice

**Chart#:** _____
FOR OFFICE USE ONLY

**Patient Name:** _____ * _____ * _____ _____
Last First MI Preferred Name

**Title:** _____ **Gender:*** ◯ Male ◯ Female **Family Status:*** ◯ Married ◯ Single ◯ Child ◯ Other
Mr/Ms/Mrs/etc

**Birth Date:*** _____ **SS#:** _____ **Prev. Visit:** _____

**Email Address:** _____ **Best time to call:** _____

**Phone:** _____ * _____ _____ _____ _____ _____
Home Mobile Work Ext Fax Other

**Address:** _____ * _____
Address 1 Address 2

_____ * _____ * _____ *
City State Zip Code

**The following is for:** ◯ the patient ◯ the person responsible for payment ◯ both ◯ not applicable

**Employer Name:** _____ **Phone:** _____

**Employer Address:** _____ _____
Address 1 Address 2

_____ _____ _____
City State Zip Code

Whom may we thank for referring you to our practice?

_____

**In an emergency who should be notified? Please enter NAME and PHONE NUMBER below: ***

_____

_____

**How may we communicate with you? (Please check all that apply) ***

- ☐ Contact me at home
- ☐ Contact me via cell phone
- ☐ Contact me at work
- ☐ Contact me via email
- ☐ Contact me via text message
- ☐ Leave messages on my home voicemail/answering machine
- ☐ Leave messages on my cell phone voicemail/answering machine
- ☐ Leave messages on my work phone voicemail/answering machine

## Release of Information

**With whom may we discuss your healthcare with? (Please keep in mind, for us to file with any insurance for you, you must check the "Insurance Company" option)**

☐ Health Care Providers ☐ Insurance Company ☐ Other, Specified Below

**If "Other, Specified below" is selected please use the space provided:**

_____

_____

## Responsible Party Information

**This only needs to be filled out if the insurance subscriber is other than patient, or you are the parent/guardian of the patient**

**The following is for:** ◯ the patient's spouse ◯ the person responsible for payment ◯ both ◯ neither-not applicable

**Name:** _____ _____ ___ _____
Last First MI Preferred Name

**Title:** _____ **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other
Mr/Ms/Mrs/etc

**Birth Date:** _____ **SS#:** _____ **DL#:** _____

**Email Address:** _____ **Best time to call:** _____

**Phone:** _____ _____ _____ _____ _____ _____
Home Mobile Work Ext Fax Other

**Address:** _____ _____
Address 1 Address 2

_____ _____ _____
City State Zip Code

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### Primary Dental Insurance:

**Name of Insured:** _____ _____ ___
Last First MI

**Insured's Birth Date:** _____ **ID #:** _____ **Group #:** _____

**Insured's Address:** _____ _____
Address 1 Address 2

_____ _____ _____
City State Zip Code

**Insured's Employer Name:** _____

**Employer Address:** _____ _____
Address 1 Address 2

_____ _____ _____
City State Zip Code

**Patient's relationship to insured:** ◯ Self ◯ Spouse ◯ Child ◯ Other

**Insurance Plan Name:** _____

**Insurance Address:** _____ _____
Address 1 Address 2

_____ _____ _____
City State Zip Code

**Insurance Company Phone Number:**

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### Insurance Authorization:

☐ **By checking this box,**
**I authorize my insurance company to pay the dentist all insurance benefits rendered.**
**I authorize the use of this electronic signature on all insurance submissions.**
**I authorize the dentist to release all information necessary to secure the payment of benefits.**
**I understand that I am financially responsible for all charges whether or not paid by insurance.**

**Secondary Dental Insurance:**

**Name of Insured:** _____ _____ _____
Last First MI

**Insured's Birth Date:** _____ **ID #:** _____ **Group #:** _____

**Insured's Address:** _____ _____
Address 1 Address 2

_____ _____ _____
City State Zip Code

**Insured's Employer Name:** _____

**Employer Address:** _____ _____
Address 1 Address 2

_____ _____ _____
City State Zip Code

**Patient's relationship to insured:** ◯ Self ◯ Spouse ◯ Child ◯ Other

**Insurance Plan Name:** _____

**Insurance Address:** _____ _____
Address 1 Address 2

_____ _____ _____
City State Zip Code

**Insurance Company Phone Number:**

**Insurance Authorization:**

☐ **By checking this box,**
**I authorize my insurance company to pay the dentist all insurance benefits rendered.**
**I authorize the use of this electronic signature on all insurance submissions.**
**I authorize the dentist to release all information necessary to secure the payment of benefits.**
**I understand that I am financially responsible for all charges whether or not paid by insurance.**

## HIPAA Acknowledgement

I understand that I may inspect or copy the protected health information described by this authorization.

I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form.

I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality,

☐ * **By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the HIPAA Disclosure Form.**

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## Appointment Cancellation and No Show Policy

To show mutual respect for your time and ours, our office hours are by appointment. Like many offices, our office will confirm your upcoming appointment as a courtesy. If you cannot make it to your appointment, please notify our office. For hygiene appointments there will be a charge of $50 per appointment for a missed, cancelled or rescheduled appointment with less than 48 business hours' notice. For any dental treatment appointment, your deposit amount will be forfeit. Please know that our business hours are Monday- Friday, from 7:30 am- 4:30 pm. We will keep a credit card number on file via a secured website to handle all missed appointment fees.

If you have any questions concerning our appointment policy please feel free to ask us.

☐ * **By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the Cancellation Policy.**

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## Consent of Dental Media

I consent to dental photos, videos and medically necessary x-rays taken before, during, and after treatment for use in my personal dental records. I consent to the use of the same by the doctor in scientific papers, demostrations, and/or presentations. I consent to the use of the same for marketing material, including but not limited to websites, printed materials, patient education. I understand, if used, that my name and other identifying information will be kept confidential. Furthermore, if used, I do not expect compensation, financial or otherwise.

**I understand the above information and checking off any of the below will serve as my electronic signature for the Consent of Dental Media. Please select all you are allowing consent for outlined in the Consent for Dental Media: ***

☐ My dental records at Hedgecock Dental

☐ Scientific papers, demostrations, and/or presentations completed by the doctors at Hedgecock Dental

☐ Marketing materials for Hedgecock Dental

**I understand that for all purposes listed in the Consent for Dental Media, excluding dental records, I may elect whether or not a full face shot may be used by selecting yes or no below: ***

◯ Yes ◯ No

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