



6836 Bee Caves Road, Building One, Suite 300 | Austin, Texas 78746 | 512.347.0044

www.TheHillsDentalSpa.com

Please Help Us Understand You!!!

Patient Name: _____

Date _____

Our office is different in that we give our patients our full attention. Schedule one patient at a time, find out what is important to them and deliver what we promise. Please answer the following so we can understand you better. Thanks!!!

In your own words, how can we help you?

Are you looking for a new dental home? yes no

Do you plan on returning to your old dentist after your treatment is complete? yes no

I am interested in:

Nonsurgical Facelift TMJ Treatment Implants Smile Makeover
 Facelift Dentures Filling Upgrade Sedation Dentistry

What is your time frame for the above? _____

The first visit is designed to answer your questions as well as to allow you to see if we are the right Dentist for you. If you feel we are not the best Dentist for you, we will be happy to refer you to who we know is a good match for you. If you feel we can help you, we will take records, do a thorough examination and give you specific options for your dental treatment.

Please begin thinking about the following:

How important are the following concepts: dental health, prevention, dental cosmetics, and facial cosmetics?

We will be discussing this with you shortly.

Thanks Again!!! Kevin Winters, D.D.S. & Kory Grahl, D.M.D.

Revised 2/10/2019

Patient Name _____ Address w/Zip _____

Employer _____ Work Phone # _____

Home Phone # _____ Cell Phone # _____

Email _____ SSN _____

Primary Physician's Name _____ Physician Phone# _____

Date of Last Physical _____ Date of Birth _____

Spouse Name _____ Spouse Phone # _____

Emergency Contact _____ Contact Phone # _____

**Do you have or have you ever had:
Place a mark on "yes" or "no" to**

- | | | | | | |
|---|--|------------------------|--|--------------------|--|
| AIDS/HIV | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Murmur | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| ANEMIA | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tumor or growth on | |
| Arthritis, Rheumatism | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis Type _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No | Head/Neck | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Heart Valves | <input type="checkbox"/> Yes <input type="checkbox"/> No | High Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No | Ulcer | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Joints | <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sleep Apnea | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No | Liver Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Snoring | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bleeding abnormally,
with extractions or surgery | <input type="checkbox"/> Yes <input type="checkbox"/> No | Mitral Valve Prolapse | <input type="checkbox"/> Yes <input type="checkbox"/> No | Headaches | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Blood Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Nervous Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Jaw Pain | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pacemaker | <input type="checkbox"/> Yes <input type="checkbox"/> No | Jaw Popping | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chemotherapy | <input type="checkbox"/> Yes <input type="checkbox"/> No | Psychiatric Care | <input type="checkbox"/> Yes <input type="checkbox"/> No | Limited Opening | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Circulatory Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Radiation Treatment | <input type="checkbox"/> Yes <input type="checkbox"/> No | Congested Ears | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cortisone Treatments | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatic Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No | Dizziness | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cough, persistent | <input type="checkbox"/> Yes <input type="checkbox"/> No | Scarlet Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No | ringing Ears | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sinus Trouble | <input type="checkbox"/> Yes <input type="checkbox"/> No | Posture Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Epilepsy | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke | <input type="checkbox"/> Yes <input type="checkbox"/> No | Clenching | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Fainting or dizziness | <input type="checkbox"/> Yes <input type="checkbox"/> No | Swollen Feet or Ankles | <input type="checkbox"/> Yes <input type="checkbox"/> No | Grinding | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Glaucoma | <input type="checkbox"/> Yes <input type="checkbox"/> No | Swollen Neck Glands | <input type="checkbox"/> Yes <input type="checkbox"/> No | Facial Pain | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Heart Lesions | <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Neck Ache | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | | Tonsillitis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Bell's palsy | <input type="checkbox"/> Yes <input type="checkbox"/> No |

List any medications you are currently taking: Please include any blood thinning medications or aspirin?

Are you allergic to any medications or other substances?

Circle if you have seen: **an Orthodontist -had your bite adjusted- had any bite related treatment - TMJ Joint Surgery**

Have you taken or currently taking medications for osteoporosis known as bisphosphonates for example Fosamax, Actonel, or Boniva?

____yes ____no List Medication _____

Circle if you have seen any of the following healthcare professionals: **ENT, Neurologist, Chiropractor, or Massage Therapist.**

Have you ever had **Botox** and/or **Facial Fillers**? ____yes ____no

Do you snore, use a CPAP or had a sleep study? ____yes ____no

Have you had radiation to the head and/or neck? ____yes ____no

Do you use tobacco products? ____yes ____no

Signature: _____

Date: _____

What We Believe All Patients Deserve

1. To be given a full dental assessment & treatment plan, both when new to the practice, and periodically thereafter, so that each patient may accomplish the level of dental health and aesthetics that they want to achieve.
2. To be treated with the respect and dignity in a guilt free environment, especially related to any dental health issues the patient is now experiencing.
3. To have all treatment completed in a comfortable manner; to have options for sedation by Nitrous Oxide (laughing gas), sedation by pill form, or more complete sedation as needed.
4. To be seen on time and to never be required to wait.
5. To have all treatment completed on time in the least amount of appointments possible.
6. To have access to the best materials, laboratories, technology, and techniques available in dentistry today.
7. For patients with dental insurance, all treatment to be driven and guided for the benefit of the patient and not for the benefit of the insurance company and for the dental office to file all paperwork and explain all dental benefits to patient.
8. To receive multiple payment options as well as long term payment plans and for all cost of treatment to be fully explained and in writing.
9. To receive a guarantee, both in terms of results and in terms of time guarantees.
10. For the dental office to be available for fast and expedient emergency treatment 24 hours a day, 7 days a week.



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