Gonzalez FAMILY DENTISTRY

DR. DEMETRIO M. GONZALEZ, DDS

WWW.GONZALEZFAMILYDENTISTRY.COM
Tel: 361-985-7422
5622 EVERHART RD.
CORPUS CHRISTI, TX 78411

PATIENT INFORMATION

Date: ☐NEW PATIENT ☐UPDATE

Patient Name: LAST FIRST MI PREFERRED TITLE

☐MALE ☐FEMALE ☐SINGLE ☐MARRIED

PATIENT'S DOB: _____

PATIENT'S SSN: _____

*IF CHILD, PROVIDE PARENT/GUARDIAN NAME(S) BELOW:
_____

Address: ADDRESS LINE 1
ADDRESS LINE 2
CITY ST ZIP CODE

HOME:
CELL:

E-Mail:

How did you hear about our office? _____

EMERGENCY INFORMATION

In case of emergency, please provide information for the nearest relative or designated contact person not at the patient's address:

NAME RELATIONSHIP Tel:

EMPLOYMENT INFORMATION

Employer: Occupation:

Address: ADDRESS LINE 1
ADDRESS LINE 2
CITY ST ZIP CODE

WORK: X
DIRECT:

E-Mail:

INSURANCE INFORMATION

Subscriber: LAST FIRST MI PREFERRED TITLE

Subscriber Date of Birth: Subscriber SSN:

Subscriber Employer:

Patient Relationship to Subscriber: ☐SELF ☐SPOUSE ☐CHILD ☐OTHER

PRIMARY INSURANCE CARRIER:

Group/Policy No.: ID No.:

Address: CITY ST ZIP CODE

TEL:
TOLL-FREE:
FAX:

Gonzalez FAMILY DENTISTRY

DR. DEMETRIO M. GONZALEZ, DDS

WWW.GONZALEZFAMILYDENTISTRY.COM
Tel: 361-985-7422
5622 EVERHART RD.
CORPUS CHRISTI, TX 78411

PREVIOUS DENTIST INFORMATION

Dentist: _____ Telephone: _____

Clinic/Facility: _____

Address: _____

_____
CITY ST ZIP CODE

Reason for changing: _____

DENTAL HISTORY

ORAL HEALTH: ☐EXCELLENT ☐GOOD ☐FAIR ☐POOR

Date of Last Dental Visit: _____ Treatment Type: _____

☐Y ☐N Are you currently having dental discomfort? If yes, explain: _____
☐Y ☐N Any unhappy/unpleasant dental experiences? If yes, explain: _____
☐Y ☐N Any injuries to mouth/teeth/head? If yes, explain: _____
☐Y ☐N Any missing teeth other than wisdom teeth or orthodontic extractions?
☐Y ☐N Have missing teeth been replaced?
☐Y ☐N Orthodontic appliances(braces) now or in the past?
☐Y ☐N Gums bleed when brushing or flossing?
☐Y ☐N Concerned about gum disease? History of gum disease? ☐Y ☐N
☐Y ☐N Any concerns about the appearance of your teeth?
☐Y ☐N Does it hurt to bite or chew?
☐Y ☐N Do you clench or grind your teeth? If so, do you wear a night guard or splint? ☐Y ☐N
☐Y ☐N Does any type of dental treatment make you nervous? If yes, please explain below:

_____

The most important concerns regarding my dental treatment are:

_____

What factors are most important for your satisfaction with our office?

_____

Any additional concerns/comments?

_____

CHILD/MINOR PATIENTS: PLEASE ANSWER THE FOLLOWING QUESTIONS:

☐Y ☐N Any mouth habits? (Thumb sucking, nail biting, mouth breathing, nursing/bottle habits, pacifier, etc.)

_____

☐Y ☐N Any unusual speech habits? If yes, explain: _____
☐Y ☐N Any lost teeth? If yes, list: _____
☐Y ☐N Does the patient receive assistance with brushing and flossing? If yes, how often?

_____

PRIMARY PHYSICIAN INFORMATION

Physician: _____ Telephone: _____

Clinic/Facility: _____

Gonzalez FAMILY DENTISTRY

DR. DEMETRIO M. GONZALEZ, DDS

WWW.GONZALEZFAMILYDENTISTRY.COM
Tel: 361-985-7422
5622 EVERHART RD.
CORPUS CHRISTI, TX 78411

MEDICAL HISTORY

GENERAL HEALTH: ☐EXCELLENT ☐GOOD ☐FAIR ☐POOR

☐Y ☐N Under a physician's care now?
☐Y ☐N Any hospitalization in the past 5 years?
☐Y ☐N Any serious illnesses/surgeries?
☐Y ☐N Use tobacco in any form? If Yes, Type:
☐Y ☐N Is pre-medication required before dental visits due to heart condition or artificial joint?
☐Y ☐N Taking any prescription or daily over the counter medications/drugs? *If yes, list details in the Medication Section.*

FEMALE PATIENTS: ☐Y ☐N Currently nursing? ☐Y ☐N Currently pregnant? Due Date:

Do you know of any reason why routine dental procedures might pose a risk to you, our staff, or other patients? ☐Y ☐N
If yes, please describe:

Is there anything important about your medical condition we have not asked? ☐Y ☐N If yes, please describe:

Are you currently using or have you ever taken Oral or IV Bisphosphonates? ☐Y ☐N

PATIENTS: DO YOU HAVE, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY): ☐NONE

☐ACID REFLUX	☐BULIMIA	☐HEARING PROBLEMS	☐PSYCHIATRIC TREATMENT
☐ADHD	☐CANCER/MALIGNANCY	☐HEART ATTACK	☐RADIATION/CHEMO
☐AIDS/HIV	☐CEREBRAL PALSY	☐HEART DISEASE	☐RESPIRATORY DISEASE
☐ANEMIA	☐CHEMICAL DEPENDENCY	☐HEART MURMUR	☐RHEUMATIC FEVER
☐ANOREXIA	☐CHICKEN POX	☐HEPATITIS	☐SINUS PROBLEMS
☐ANXIETY	☐CONVULSIONS	☐HIGH BLOOD PRESSURE	☐STROKE
☐ARTIFICIAL HEART VALVE	☐DEPRESSION	☐KIDNEY DISEASE	☐THYROID CONDITION
☐ARTIFICIAL JOINTS	☐DIABETES	☐LIVER PROBLEMS	☐TUBERCULOSIS
☐ARTHRITIS	☐DIZZINESS/FAINTING	☐MITRAL VALVE PROLAPSE	☐ULCERS
☐ASTHMA	☐EPILEPSY/SEIZURES	☐MONONUCLEOSIS	☐VENEREAL DISEASE
☐AUTISM/ASPERGER'S	☐FREQUENT EAR INFECTIONS	☐PACEMAKER	
☐BLEEDING DISORDER	☐FREQUENT HEADACHES	☐OTHER – PLEASE LIST:	

PATIENTS: ARE YOU ALLERGIC TO OR HAVE YOU EVER HAD ANY REACTION TO THE FOLLOWING? (CHECK ALL THAT APPLY): ☐NONE

☐ASPIRIN	☐CODEINE	☐LACTOSE INTOLERANCE	☐SLEEPING PILLS
☐ANESTHETIC – LOCAL	☐DAIRY	☐METAL SENSITIVITY	☐SULFA DRUGS
☐BARBITURATES	☐LATEX	☐NITROUS OXIDE SEDATION	☐PENICILLIN/OTHER ANTIBIOTICS
☐OTHER – PLEASE LIST:			

MEDICATION INFORMATION

PATIENTS: ARE YOU CURRENTLY TAKING ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY): ☐NONE

☐ANTIBIOTICS/SULFA DRUGS	☐ANTIHISTAMINES/ALLERGY	☐DAILY ASPIRIN	☐BLOOD PRESSURE MEDICATIONS
☐BLOOD THINNERS	☐CANCER/CHEMO MEDICATIONS	☐CORTISONE/STEROIDS	☐HEART MEDICATION/DIGITALIS
☐INSULIN	☐NITROGLYCERIN	☐ORAL CONTRACEPTIVES	☐OSTEOPOROSIS MEDICATIONS
☐OTHER DIABETIC MEDICATIONS	☐RECREATIONAL DRUGS	☐THYROID MEDICATIONS	☐TRANQUILIZERS
☐OTHER (PLEASE LIST BELOW)			

DRUG NAME	DOSAGE	REASON PRESCRIBED

Gonzalez FAMILY DENTISTRY

DR. DEMETRIO M. GONZALEZ, DDS

WWW.GONZALEZFAMILYDENTISTRY.COM
Tel: 361-985-7422
5622 EVERHART RD.
CORPUS CHRISTI, TX 78411

Financial Guidelines

We are committed to providing you with the best care possible to achieve total oral health. To achieve these goals, we need your assistance and your understanding of our financial guidelines.

Insurance

We accept most major dental insurance payments; however, we may not be an in-network provider for your plan. If we are not an in-network provider, review your plan details, as in many cases insurance reimbursement is very similar.

- **We are in network with most PPO dental plans Medicaid & CHIP.**
- **No estimate is a guarantee of payment.** Please understand, you are responsible for all charges not paid by your insurance. Also, many insurance companies are excluding certain dental procedures or downgrading procedures to a lesser reimbursement level; in which case, you would be responsible for the difference.
- **Minors must be accompanied by a parent or legal guardian**. If the parents are separated or divorced, the person accompanying the minor will be responsible for copayment at the time of service.

Payments

- **Patient portion or patient co-pay is due at the time services are rendered** - unless prior financial arrangements have been made.
- **Payment Information:**
  - All major credit cards are accepted (Visa, MasterCard, Discover)
  - Cash, Personal Checks
  - Various financing options with CareCredit®
- **Balances left over 90 days will incur an 18% or $10 minimum monthly finance charge.** We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

Cancelled/ Missed Appointments (must read)

- If you cannot make an appointment as scheduled, please notify our office. If you wish to cancel or reschedule your appointment, there must be a 24-hour notice. If your appointment is canceled or rescheduled the day of your appointment or you NO-SHOW, there will be a **$25** reschedule/cancelation/No-Show fee. When you come in to your appointment, the fee must be paid. We provide a 15-minute grace period after your appointment time. If you arrive 15-minutes late to your appointment, we have the right to reschedule you. If there are a total of 3 or more broken appointments, you will be placed in Walk-In bases. Which means, if you call to schedule an appointment we will not schedule you. You must come in without an appointment and running the risk we might not see you. We will be seeing the patients in our schedule first and then we will accommodate you to our schedule.

By signing below, I acknowledge I have read and understand the guidelines above.

Signature: _____ Date: _____

DR. DEMETRIO M. GONZALEZ, DDS

WWW.GONZALEZFAMILYDENTISTRY.COM
Tel: 361-985-7422
5622 EVERHART RD.
CORPUS CHRISTI, TX 78411

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

Updated 2013

My signature confirms that I have been informed of my rights to privacy regarding my protected personal and health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand the terms in which my personal health and identification information may be used.

I have been informed of my dental provider's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices*. I understand that my dental provider has the right to change the *Notice of Privacy Practices* and that I may contact this office at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

A copy of our acknowledgement of privacy practices is available for you records.

Signature: _____ **Date:** _____

RELATIONSHIP TO PATIENT: ☐ADULT PATIENT ☐PARENT ☐GUARDIAN ☐OTHER

☐ I give permission for the following communications to be used by Dr. Demetrio M. Gonzalez, DDS (**please check all that apply**):

☐ Cell phone: ☐ Text Message reminders permitted
☐ Home phone ☐ Work ☐ E-Mail:

☐ I am granting permission for Dr. Demetrio M. Gonzalez, DDS to disclose their identity to anyone who may answer my home, work or cell phone.

☐ I am granting permission for Dr. Demetrio M. Gonzalez, DDS to leave a message with any person who may answer my phone or on my voicemail of the following numbers **(please check all that apply)**:

☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ None- please just ask for a call back
☐ Other (Please explain)

I would like to give permission for the following person(s) to bring to dental appointments and have access to personal information including but not limited to treatment, and billing of myself and any dependent children listed above:

1) **Name:** _____ **Patients Relationship:** _____
2) **Name:** _____ **Patients Relationship:** _____
3) **Name:** _____ **Patients Relationship:** _____
4) **Name:** _____ **Patients Relationship:** _____
5) **Name:** _____ **Patients Relationship:** _____

Gonzalez FAMILY DENTISTRY

DR. DEMETRIO M. GONZALEZ, DDS

WWW.GONZALEZFAMILYDENTISTRY.COM
Tel: 361-985-7422
5622 EVERHART RD.
CORPUS CHRISTI, TX 78411

PATIENT CONSENT- PAYMENT AUTHORIZATION – SIGNATURE ON FILE

To the best of my knowledge, all the preceding answers are correct. If I have any changes in my health status of if my medication changes, I shall inform the dentist and staff at the next appointment without fail.

I hereby authorize payment directly to Dr. Demetrio M. Gonzalez, DDS of the dental benefits otherwise payable to me.

I hereby authorize Dr. Demetrio M. Gonzalez, DDS to release any information concerning my health or dental care, advice, treatment or supplies provided. This information is to be used in administering dental claims and/or discussing treatment options with other dental professionals.

I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance on my account for any professional services rendered.

By signing below, I acknowledge that I have read and understand the statements mentioned above.

Signature: _____ Date: _____

TREATMENT ROOM POLICY

- **NO food or drinks in the treatment rooms.**
- **NO taking/making phone calls or videotaping patient when in treatment. If making or receiving a call, please step out of the room and use your cell phones in the lobby or outside.**
- **Respect the privacy of all our patients. (Do not disclose any medical information or anything in relation to a patient that is present in our office, this is considered a patient privacy violation)**
- **NO talking while Dr. Gonzalez is examining the patient or explaining treatment to the patient. (Otherwise asked by the doctor)**
- **When Dr. Gonzalez is treating the patient, do not disturb him. The instruments being used may affect the patient with any wrong movement or distraction. If needed to ask a question, please let him know or the assistant. Any disturbance or distractions might back up the treatment for the patient.**
- **Parents with small children: We highly recommend for the small children NOT being seen by the dentist, be kept in the lobby in company of an adult.**

By signing below, I acknowledge that I have read and understand the statements mentioned above.

Signature: _____ **Date:** _____