Gonzalez FAMILY DENTISTRY

DR. DEMETRIO M. GONZALEZ, DDS

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

PATIENT INFORMATION

Date: _____

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

_____
CITY ST ZIP CODE

HOME: _____

CELL: _____

Email: _____

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:

_____ Tel: _____
NAME RELATIONSHIP

EMPLOYMENT INFORMATION

Employer: _____ Occupation: _____

INSURANCE INFORMATION *(IF DIFFERENT OF WHAT WE HAVE ON FILE)*

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: _____ TEL: _____

FAX: _____

_____
CITY ST ZIP CODE

Pharmacy: _____ Location: _____

PREVIOUS DENTIST INFORMATION

Dentist: _____ Telephone: _____

Reason for changing: _____

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DENTAL HISTORY

Date of Last Dental Visit: _____ Treatment Type: _____

☐Y ☐N Bad Breath
☐Y ☐N Bleeding Gums
☐Y ☐N Clicking and popping jaw
☐Y ☐N Loose teeth or broken fillings

☐Y ☐N Food collection between teeth
☐Y ☐N Grinding or clenching teeth
☐Y ☐N Periodontal Treatment
☐Y ☐N Sensitivity to cold

☐Y ☐N Sensitivity to sweets
☐Y ☐N Sensitivity when biting
☐Y ☐N Sores or growths in mouth
☐Y ☐N Sensitivity to hot

How often to you brush your teeth?

_____

How do you feel about the appearance of your teeth?

_____

PRIMARY PHYSICIAN INFORMATION

Physician: _____ Telephone: _____

Clinic/Facility: _____

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: _____

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

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

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

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

_____

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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

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

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:** _____

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:** _____ **Relationship to Patient:** _____

2) **Name:** _____ **Relationship to Patient:** _____

BY SIGNING ANY FINANCIAL OR TREATMENT FORMS, PATIENTS ACKNOWLEDGE RESPONSIBILTY FOR ANY CHARGES NOT COVERED BY INSURANCE. THE OFFICE IS NOT RESPONSIBLE FOR ANY FORMS SIGNED WITHOUT REVIEW.

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FINANCIAL GUIDELINES

Insurance:

We accept most major dental insurances; however, we are not an in-network provider. Meaning you may pay slightly more than you would if you went to an in-network provider; this alternative allows us to use the best materials available and allocate enough time to deliver the best care possible. In many cases you may have an insurance reimbursement - review your plan details. At times the insurance may send a check payment to the subscriber instead of us.

*We do accept Medicaid & CHIP (For children under age 21 only)

*No estimate is a guarantee of payment.

Please understand you are responsible for all charges not paid by your insurance

And that we are a OUT OF NETWORK PROVIDER initials: _____

*Minors must be accompanied by a parent, legal guardian or somone over the age of 18 years old.

Payments:

-Patient portion or patient co-pay is due when services are rendered. If you are not able to pay for your dental treatment, your appointment will have to be rescheduled.

-Payment Information:

-All major credit cards are accepted (Visa, MasterCard, Discover)

-Cash, Personal Checks (Under $150 ONLY)

-Financing Available:

-In-office Financing* and Care Credit

In-house financing restrictions apply. The front staff will discuss the information with the patient/parent/guardian.

Signature: _____ **Date:** _____

CANCELLED/NO-SHOW POLICY

If you cannot make an appointment as scheduled, please notify our office as soon as possible. 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 reschedule/cancelation/no-show fee that must be paid prior to continuation of treatment in the amount of $50.00. We provide a 10-minute grace period after your appointment time. If you arrive at the 10-minute mark to your scheduled appointment, we reserve the right to reschedule you. If the patient has Medicaid or CHIP, the insurance is notified about any missed appointments. If there is more than 3 missed appointments, the insurance will remove the patient from our roster. This means, we will not be able to see the patient in our office anymore.

Signature: _____ **Date:** _____