



artistic smiles
BY ANGELA GONZALEZ, D.D.S.

We would like to welcome you to our office. In an effort to provide the best service possible, we ask you to fill out this form as completely as possible.

Thank You!

Patient Information

Patient Name: _____
 Male Female Social Security Number: _____
Birth Date: _____ Driver License: _____
Home Address: _____
City: _____ State: _____ Zip: _____
Primary Phone: _____ home cell Ok to leave message? Yes No
Secondary Phone: _____ home cell other Ok to leave message? Yes No
E-mail: _____
Employer's Name: _____ Occupation: _____

Spouse / Partner Information

Marital Status Single Married Divorced Widowed Significant Other
Spouse/Partner's Name: _____
Emergency Contact Name: _____
Phone Number: _____ Relation: _____
Address: _____
City: _____ State: _____ Zip: _____
Person(s) OK to release appointment or medically related information to concerning you:
_____ Relation(s): _____

Insurance Information

Primary Insurance Company: _____ Phone Number: _____
Group Number: _____ Policy Number: _____
Member ID Number: _____ Policy Holder's Name: _____
Relation: _____ Policy Holder's SSN: _____
Policy Holder's Date of Birth: _____
Employer: _____ Work Phone Number: _____
Co-pay (if known): _____ Deductible (if known): _____

Secondary Insurance Company: _____ Phone Number: _____
Group Number: _____ Policy Number: _____
Member ID Number: _____ Policy Holder's Name: _____
Relation: _____ Policy Holder's SSN: _____
Policy Holder's Date of Birth: _____
Employer: _____ Work Phone Number: _____
Co-pay (if known): _____ Deductible (if known): _____

Dental History

How did you hear about our Practice? Ad Internet Family/Friend Physician Other
Name of person referring (if applicable) : _____

Have your tonsils or adenoids been removed? Yes No

Have you ever experienced jaw joint pain/ discomfort (TMJ/TMD)? Yes No

Do you have any missing or extra permanent teeth? Yes No

Have you ever had an injury to (select all that apply): Teeth Mouth Chin

Do you have speech problems? Yes No

If so, explain: _____

Do your gums bleed? Yes No Do you smoke? Yes No Do you like your smile? Yes No

Do you currently or have you ever had any of the following habits (check all that apply)

- Clenching/Grinding Teeth
 - Lip Sucking/Biting
 - Mouth Breathing
 - Nail Biting
 - Thumb/Finger Sucking
 - Chewing/Eating Problem
-

Medical History

Are you currently being treated by a physician? Yes No

Reason: _____ Physician: _____

Last Visit: _____ Phone: _____

Do you have any allergies/sensitivities to medications or latex? Yes No

If yes, please list: _____

Are you currently taking any prescription or over-the-counter medications? Yes No

Please list, with dosage: _____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Apidex, Fastin (brand names of Phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine)?

Yes No

Have you had any serious illnesses or operations? If yes, describe:

Have you ever had a blood transfusion? Yes No

If yes, give approximate dates: _____

(Women) Are you pregnant? Yes No Nursing? Yes No Taking birth control pills? Yes No

Check if you have or have ever had any of the following:

Anemia Arthritis, Rheumatism Artificial Heart Valves Artificial Joints Asthma

Back Problems Blood Disease Cancer Chemical Dependency Chemotherapy

Circulatory Problems

Cortisone Treatments Cough, Persistent Coughing Blood Diabetes Epilepsy Fainting

Glaucoma Headaches Heart Murmur Heart Problems Hemophilia

Hepatitis High Blood Pressure HIV/AIDS Jaw Pain Kidney Disease Liver Disease

Mitral Valve Prolapse Pacemaker Radiation Treatment Respiratory Disease Rheumatic Fever

Scarlet Fever Shortness of Breath Skin Rash Stroke Swelling of Feet or Ankles

Thyroid Problems Tobacco Habit Tonsillitis Tuberculosis Ulcer Venereal Disease (STD)

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence and it is my responsibility to inform the office of any changes in my medical status.

I hereby authorize the release of any information pertaining to my medical treatment necessary to process any insurance claims. I further authorize the application for benefits on my behalf for covered services and payment of any benefits to the office. I understand that I am responsible for any amount not covered by insurance.

I understand that where appropriate, credit bureau reports may be obtained.

Submitted by: _____ Date: _____