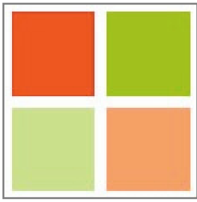

Family Dentistry of Gonzales

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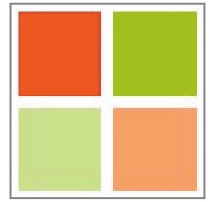

Patient Information & Health History Form

To help us meet all your healthcare needs, please fill out this form completely in ink.
If you have any questions or need assistance, please ask us and we will be happy to help.

Patient Information (Confidential)

Name ______ Birth Date ______ Age ______ Today's Date ______ Patient Number ______

Social Security # ______ Driver's License # ______ Home Phone ______ Mobile Phone ______ Work Phone ______

Mailing Address ______ City ______ State ______ Zip ______

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated Gender: ☐ Male ☐ Female

Patient or Parent's Employer ______ Work Phone ______

Business Address ______ City ______ State ______ Zip ______

Spouse or Parent's Name ______ Spouse or Parent's Employer ______ Spouse or Parent's Work Phone ______

Whom may we thank for referring you? ______

Person to Contact in Case of Emergency ______ Phone ______ Relationship to Patient ______

If Student, Name of School/College ______ City ______ State ______ Zip ______ ☐ Full Time ☐ Part Time

Financial Responsibility

Name of Person Financially Responsible for this Account ______ Relationship to Patient ______

Street Address ______ City ______ State ______ Zip ______

Social Security Number ______ Driver's License Number (State) ______ Birth Date ______

Employer ______ Work Phone ______ Financial Institution ______

Is this person currently a patient in our office? ☐ Yes ☐ No

For your convenience, we accept the following methods of payment. Please check the option you prefer.
☐ Cash ☐ Personal Check ☐ Credit Card ☐ VISA ☐ MasterCard ☐ Discover ☐ I wish to apply for Care Credit
NOTE: Payment in full is expected at each appointment.

Dental Insurance Information

Name of Insured ______ Relationship to Patient ______ Birth Date ______ Social Security Number ______

Employer ______ Work Phone ______ Date Employed ______

Employer's Street Address ______ City ______ State ______ Zip ______

Insurance Company ______ Group Number ______ Policy ID Number ______

Insurance Company Street Address ______ City ______ State ______ Zip ______

How much is your deductible? ______ How much have you used? ______ Max Annual Benefit Amount ______

Dental Insurance Information (continued)

Do you have any additional dental insurance? ☐Yes ☐ No If yes, please complete the following information.

Name of Insured ______ Relationship to Patient ______ Birth Date ______ Social Security Number ______

Employer ______ Work Phone ______ Date Employed ______

Employer's Street Address ______ City ______ State ______ Zip ______

Insurance Company ______ Group Number ______ Policy ID Number ______

Insurance Company Street Address ______ City ______ State ______ Zip ______

How much is your deductible? ______ How much have you used? ______ Max Annual Benefit Amount ______

Patient Medical History

Name of Physician ______ Office Phone ______ Date of Last Exam ______

Are you under a physician's care now? ☐ Yes ☐ No If yes, please explain:______

Have you ever been hospitalized or had a major operation? ☐ Yes ☐ No If yes, please explain:______

Have you ever had a serious head or neck injury? ☐ Yes ☐ No If yes, please explain:______

Are you taking any medications, pills, or drugs? ☐ Yes ☐ No If yes, please explain:______

Do you take, or have you taken, Phen-Fen or Redux? ☐ Yes ☐ No If yes, please explain:______

Are you on a special diet? ☐ Yes ☐ No If yes, please explain:______

Do you use tobacco? ☐ Yes ☐ No If yes, please explain:______

Do you use controlled substances? ☐ Yes ☐ No If yes, please explain:______

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ☐ Yes ☐ No If yes, please explain:______

Women: Are you … ☐ Pregnant ? ☐ Trying to get pregnant? ☐ Taking oral contraceptives? ☐ Nursing?

Any allergies to the following? ☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics
☐ Other (please explain) ______

Do you have, or have you ever had, any of the following?

☐ AIDS/HIV Positive
☐ Alzheimer's Disease
☐ Anaphylaxis
☐ Anemia
☐ Angina
☐ Arthritis/Gout
☐ Artificial Heart Valve
☐ Artificial Joint
☐ Asthma
☐ Blood Disease
☐ Blood Transfusion
☐ Breathing Problem
☐ Bruise Easily
☐ Cancer
☐ Chemotherapy
☐ Chest Pains
☐ Cold Sores/Fever Blisters
☐ Congenital Heart Disorder
☐ Convulsions
☐ Cortisone Medicine
☐ Diabetes
☐ Drug Addiction
☐ Easily Winded
☐ Emphysema
☐ Epilepsy or Seizures
☐ Excessive Bleeding
☐ Excessive Thirst
☐ Fainting Spells/Dizziness
☐ Frequent Cough
☐ Frequent Diarrhea
☐ Frequent Headaches
☐ Genital Herpes
☐ Glaucoma
☐ Hay Fever
☐ Heart Attack/Failure
☐ Heart Murmur
☐ Heart Pace Maker
☐ Heart Trouble/Disease
☐ Hemophilia
☐ Hepatitis A
☐ Hepatitis B or C
☐ Herpes
☐ High Blood pressure
☐ High Cholesterol
☐ Hives or Rash
☐ Hypoglycemia
☐ Irregular Heartbeat
☐ Kidney Problems
☐ Leukemia
☐ Liver Disease
☐ Low Blood Pressure
☐ Lung Disease
☐ Mitral Valve Prolapse
☐ Osteoporosis
☐ Pain in Jaw Joints
☐ Parathyroid Disease
☐ Psychiatric Care
☐ Radiation Treatments
☐ Recent Weight Loss
☐ Renal Dialysis
☐ Rheumatic Fever
☐ Rheumatism
☐ Scarlet Fever
☐ Shingles
☐ Sickle Cell Disease
☐ Sinus Trouble
☐ Spina Bifida
☐ Stomach/Intestinal Disease
☐ Stroke
☐ Swelling of Limbs
☐ Thyroid Disease
☐ Tonsillitis
☐ Tuberculosis
☐ Tumors or Growths
☐ Ulcers
☐ Venereal Disease
☐ Yellow Jaundice

Have you ever had any serious illness not listed above? ☐ Yes ☐ No If yes, please explain: ______
______

Patient Dental History

____ ________________________

Name of Previous Dentist — Date of Last Exam

____________________________________ ____________ _______________

Previous Dentist's Location — Date of Last X-Rays — Date of Last Cleaning

Question	Answer
Do your gums bleed while brushing or flossing?	☐ Yes ☐ No
Are your teeth sensitive to hot or cold liquids/foods?	☐ Yes ☐ No
Are your teeth sensitive to sweet or sour liquids/foods?	☐ Yes ☐ No
Do you feel pain to any of your teeth?	☐ Yes ☐ No
Do you have any sores or lumps in or near your mouth?	☐ Yes ☐ No
Have you ever experienced any of the following problems in your jaws?	
- Clicking?	☐ Yes ☐ No
- Pain (joint, ear, side of face)?	☐ Yes ☐ No
- Difficulty opening or closing?	☐ Yes ☐ No
- Difficulty in chewing?	☐ Yes ☐ No
Have you had any head, neck, or jaw injuries?	☐ Yes ☐ No
Do you have frequent headaches?	☐ Yes ☐ No
Do you clench or grind your teeth?	☐ Yes ☐ No
Do you bite your lips or cheeks frequently?	☐ Yes ☐ No
Have you ever had any difficult extractions before?	☐ Yes ☐ No
Have you ever had any prolonged bleeding following extractions?	☐ Yes ☐ No ☐ Yes ☐ No
Have you had any orthodontic treatment?	☐ Yes ☐ No
Do you wear dentures or partials? If yes, date of placement ________________	
Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	☐ Yes ☐ No
Do you like your smile?	☐ Yes ☐ No

Patient Consent and Responsibility

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I hereby authorize the doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the patient's dental needs. I also authorize the doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that the doctor choose and employ such assistance as deemed fit to provide recommended treatment.

Lastly, I understand that all responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at time services are rendered. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. In the event payment is not received by the agreed upon date, or 30 days, I understand that a 1-1/2 % finance charge (18% APR) may be added to my account. In the event my account balance would be over 90 days past due, I understand my account may be charged a 25% delinquent fee and turned over to a collection agency for legal action and reported to a national credit bureau.

____ ____________________

Signature of Patient (or parent/guardian if minor) — Date

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