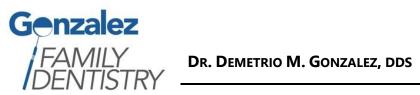


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PATIENT INFORMATION						
Date:						
Patient Name:						
	LAST	FIRST	MI	Preferred	TITLE	
		□MALE □FEMALE		□SINGLE □MARRIED		
PATIENT'S DOB:						
PATIENT'S SSN:		_	*IF CHILD, PROVIDE P	PARENT/GUARDIAN NAME(S) BE	ELOW:	
Address: Address Line 1						
	Address Line 2			HOME:		
	ADDRESS LINE 2			Cell:		
E-Mail:	Сіту	ST	ZIP CODE			
L Maii.			ar about our office:	•		
			CY INFORMATION			
In case of eaddress:	emergency, please provide	information for the ne	earest relative or desig	nated contact person not at	the patient's	
addiess.				Tel:		
NAME		RELATIONS	SHIP			
		EMPLOYME	ENT INFORMATION			
Employer:		Oc	cupation:			
Address:	·		\\	Work Phone:		
	CITY	ST	ZIP CODE			
E-Mail:						
INSURANCE INFORMATION (IF DIFFERENT OF WHAT WE HAVE ON FILE)						
Subscriber	LAST	FIRST	MI	Preferred	TITLE	
Subscriber Date of Birth: Subscriber Employer:			Subscriber SSN:			
Patient Relationship to Subscriber: Self Spouse CHILD OTHER						
PRIMARY INSURANCE CARRIER:						
Group/Policy No.: ID No.:						
Address:			_	TEL: FAX:		
	CITY	ST	7IP CODE	1700		



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PREVIOUS DEM	NTIST INFORMATION				
Dentist: Telephone:					
Reason for changing:					
	AL HISTORY				
Date of Last Dental Visit: Treatment Type: _		ı			
□Y □N Bad Breath □Y □N Food collect □Y □N Bleeding Gums □Y □N Grinding or	clenching teeth	☐Y ☐N Sensitivity to sweets ☐Y ☐N Sensitivity when biting			
□Y □N Clicking and popping jaw □Y □N Periodonta □Y □N Loose teeth or broken fillings □Y □N Sensitivity		☐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 PHYS	SICIAN INFORMATIO	N			
Physician:	Telephone:				
Clinic/Facility:					
MEDIC	CAL 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 vis	its due to heart cond	lition or artificial joint?			
☐Y ☐N Taking any prescription or daily over the counte Section.	er medications/drugs?	If yes, list details in the Medication			
FEMALE Y N Currently Y	N Currently				
PATIENTS: nursing? pregnar	-	Due Date:			
PATIENTS: DO YOU HAVE, OR HAVE YOU EVER HAD ANY OF THE I	FOLLOWING? (CHECK A	LL THAT APPLY):			
☐ACID REFLUX ☐BULIMIA	☐HEARING PROBLEMS	Psychiatric Treatment			
□ADHD □CANCER/MALIGNANCY	HEART ATTACK	RADIATION/CHEMO			
☐AIDS/HIV ☐CEREBRAL PALSY☐CHEMICAL DEPENDENCY	☐HEART DISEASE ☐HEART MURMUR	☐RESPIRATORY DISEASE ☐RHEUMATIC FEVER			
☐ ANEMIA ☐ CHEMICAL DEPENDENCY☐ CHICKEN POX☐ CHICKEN POX	HEPATITIS	SINUS PROBLEMS			
ANXIETY CONVULSIONS	HIGH BLOOD PRESSU				
ARTIFICIAL HEART VALVE DEPRESSION	KIDNEY DISEASE	THYROID CONDITION			
ARTIFICIAL JOINTS DIABETES	LIVER PROBLEMS	TUBERCULOSIS			
☐ARTHRITIS ☐DIZZINESS/FAINTING	MITRAL VALVE PROLA	PSE 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): ASPIRIN CODEINE LACTOSE INTOLERANCE SLEEPING PILLS NONE					
ASPIRIN CODEINE LACTOSE INTOLERAL					
□ANESTHETIC – LOCAL □DAIRY □METAL SENSITIVITY □BARBITURATES □LATEX □NITROUS OXIDE SEI					
□BARBITURATES □LATEX □NITROUS OXIDE SEDATION □PENICILLIN/OTHER ANTIBIOTICS □OTHER – PLEASE LIST:					



2) Name: _____

Dr. Demetrio M. Gonzalez, dds

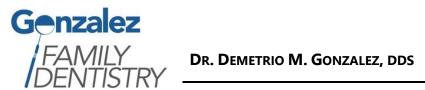
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Relationship to Patient:

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	MEDICATION INFO	RMATION			
PATIENTS: ARE YOU CURRENTLY TAKING ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY):					
□ ANTIBIOTICS/SULFA DRUGS □ BLOOD THINNERS □ INSULIN □ OTHER DIABETIC MEDICATIONS □ OTHER (PLEASE LIST BELOW) □ ANTIHISTAMIN □ CANCER/CHEI □ NITROGLYCER □ RECREATIONA	MO MEDICATIONS (C)	DAILY ASPIRIN CORTISONE/STEROIDS DRAL CONTRACEPTIVES THYROID MEDICATIONS	BLOOD PRESSURE MEDICATIONS HEART MEDICATION/DIGITALIS OSTEOPOROSIS MEDICATIONS TRANQUILIZERS		
DRUG NAME	DOSAGE	REASON PRESCRIBED			
My signature confirms that I have been informed of my rights to pr Accountability Act of 1996 (HIPAA). I understar have been informed of my dental provider's Notice of Privacy Practice have been given the right to review and receive a copy of such Notic Practices and that I may contact this office: I understand that I may request in writing that you restrict how my understand that you are not required to agree to my re-	and the terms in which my personal the terms in which my personal the secondaring a more complete secondaring a more complete secondaring the address above to obtain private information is used or	personal and health information, onal health and identification info e description of the uses and disconstand that my dental provider has a current copy of the Notice of I disclosed to carry out treatment, u do agree then you are bound to	closures of my protected health information. I as the right to change the Notice of Privacy Privacy Practices. payment or health care operations and I		
Signature:		Date			
would like to give permission for the following person(s) not limited to treatment, and 1) Name:	to bring to dental appoi	ntments and have access t	to personal information including but I above:		



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Date:

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FINANCIAL GUIDELINES

Insurance:

We accept most major dental insurances; however, we are not a in-network provider. Meaning you may pay slightly more than you would if you went to an in-network provider; however, 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*
- *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*
 - -CareCredit

Signature:

patient in our office anymore.

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

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 with DentaQuest or MCNA, 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

CANCELLED/NO-SHOW POLICY

Signature:	Date:
	•