

Welcome We would like to take this time to Welcome you and tell you about our practice. Our patients' health and comfort are very important to us, so we are always learning about new technological advances, materials, and techniques to offer the best quality of care to our patients. Starting today we hope to change your opinion of going to the dentist and create for you a dental experience like you have never had before. Please take your time in filling out all of the requested information. The information that you give us about yourself will help us take even better care of you.

Personal Information

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Ph: _____ Cell Ph: _____

E-Mail Address: _____

Employer: _____ Work Ph: _____

What is the best way for us to contact you? _____

Birthdate: _____ Social Sec. #: _____

Driver License: _____

Are you: Single Married Divorced Other

For adults: **Spouse** For children: **Responsible Parent**

Name: _____

Employer: _____

Work Ph: _____ Cell Ph: _____

Birthdate: _____ Social Sec. #: _____

Do you have any children? _____ How many? _____

Do any of your family members see another dentist? _____

Why? _____

How did you hear about us? _____

If it were one of our awesome patients who referred you, then please let us know. We would like to honor them to show our appreciation and gratitude.

Please list two people for us to contact in case of an emergency:

Name: _____

Phone: _____

Relationship: _____

Name: _____

Phone: _____

Relationship: _____

Financial Information

Who is financially responsible for the account? _____

(If different from the information listed above, please let our Financial Coordinator know. Thank you.)

Payment is due at the time services are rendered. We accept: Cash Checks Debit All Major Credit Cards

How will you be paying for your dental visits? _____

Would you like any information about payment plans that we offer supported by third party financing companies? _____

*There will be possible finance charges for late payments.

Insurance Information

Do you have any dental insurance that you will be using toward your dental visits? _____

Who is the Policy Holder for the Insurance? _____

Insurance Carrier/Company Name: _____ Provider/Member Services Ph: _____

Is the Subscriber/Employee ID different from the Policy Holder's SSN? _____ If so, what is the ID#? _____

Have you used this Insurance before? _____ If so, when? _____

Here at Dr. Simon Garza's office our main priority is to offer our patients quality care without insurance interference; however, we are more than happy to help you maximize your insurance coverage. We accept many different insurance plans and we are listed with some plans as "In-Network" or as "Preferred Providers". If you have any questions about insurance and what role it plays for our patients, please let us know and we would be more than happy to discuss it with you.

Dental History

Everyone has a different opinion about going to the dentist. The most common opinion is not very good; people associate going to the dentist with fear, discomfort, and pain. Our office plans on changing that opinion, we want our patients to know that they are going to be well taken care of and enjoy coming to the dentist. At our office your oral health is our main priority but we will need your assistance. We ask that you answer the following questions truthfully and to the best of your knowledge. Thank you, and we hope you enjoy your visit.

What is the main reason for today's visit? _____

How often do you floss? Sometimes All the time Never Comments: _____

Do your gums ever bleed? Sometimes All the time Never Comments: _____

Do you ever have clicking, popping, or discomfort in the jaw joint? Sometimes All the time Never
If so, which joint, or both? _____

Do you use tobacco products? Sometimes All the time Never Comments: _____

Have you ever had braces or any other orthodontic treatment? _____ If so, when and for how long? _____

Are any of your teeth sensitive to: Hot liquids/foods Cold liquids/foods Sweet liquids/foods Chewing Pressure
Comments: _____

Do you ever get fever blisters, canker sores, mouth ulcers, or any other oral related lesions? _____ Comments: _____

Do you have Dental Examinations and Cleanings on a routine basis? No Yes... Once a Year Twice a Year

When was your last: Cleaning: _____ Examination: _____ X-Rays: _____

Please describe what you think your current overall oral health is: _____

Have you ever wanted to change or enhance your smile? If yes, what changes would you make? _____

Are you under any stress at this time? If yes, what is causing the stress? _____

What did you like, or dislike about your past dentists and dental experiences? _____

Describe your perfect dentist/dental office: _____

What are the most convenient times for you to arrange dental visits? _____

Medical History

Please answer the following questions adequately and to the best of your knowledge. The more we know about your current medical condition and your past medical history, we will be able to better clinically treat you and avoid any situations that could arise due to a lack of information. Thank you.

Are you currently under a physician's care? _____ Name of Physician: _____ Phone: _____

If so, why? _____

Have you ever been hospitalized or had a major surgery? _____

Have you ever had a serious injury to your head or neck? _____

Are you currently taking any medications (Prescribed and/or Over-the-Counter)? _____

What, if any, medications have you taken in the past? _____

Allergies

Are you allergic to any of the following:

| | Yes | No | | Yes | No | | Yes | No |
|--------------------|--------------------------|--------------------------|------------|--------------------------|--------------------------|--------------|--------------------------|--------------------------|
| Dental Anesthetics | <input type="checkbox"/> | <input type="checkbox"/> | Aspirin | <input type="checkbox"/> | <input type="checkbox"/> | Acrylic | <input type="checkbox"/> | <input type="checkbox"/> |
| Sulfa | <input type="checkbox"/> | <input type="checkbox"/> | Penicillin | <input type="checkbox"/> | <input type="checkbox"/> | Metal | <input type="checkbox"/> | <input type="checkbox"/> |
| Iodine | <input type="checkbox"/> | <input type="checkbox"/> | Codeine | <input type="checkbox"/> | <input type="checkbox"/> | Latex Rubber | <input type="checkbox"/> | <input type="checkbox"/> |

Do you have any other known allergies? _____

Women

Are you pregnant or trying to get pregnant? _____ Are you nursing? _____ Are you taking oral contraceptives? _____

Medical Conditions

Please mark yes or no if you have ever had any of the following conditions. If you currently have any of these conditions, please circle the condition.

| | Yes | No | | Yes | No | | Yes | No |
|----------------------------|--------------------------|--------------------------|----------------------|--------------------------|--------------------------|------------------------|--------------------------|--------------------------|
| High Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> | Kidney Problems | <input type="checkbox"/> | <input type="checkbox"/> | Recent Weight Loss | <input type="checkbox"/> | <input type="checkbox"/> |
| Low Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> | Renal Dialysis | <input type="checkbox"/> | <input type="checkbox"/> | Arthritis | <input type="checkbox"/> | <input type="checkbox"/> |
| Blood Disease | <input type="checkbox"/> | <input type="checkbox"/> | 7 Disease | <input type="checkbox"/> | <input type="checkbox"/> | Drug Addictions | <input type="checkbox"/> | <input type="checkbox"/> |
| Anemia | <input type="checkbox"/> | <input type="checkbox"/> | Venereal Disease | <input type="checkbox"/> | <input type="checkbox"/> | Tumors or Growths | <input type="checkbox"/> | <input type="checkbox"/> |
| Leukemia | <input type="checkbox"/> | <input type="checkbox"/> | AIDS | <input type="checkbox"/> | <input type="checkbox"/> | Heart Disease | <input type="checkbox"/> | <input type="checkbox"/> |
| Lung Disease | <input type="checkbox"/> | <input type="checkbox"/> | HIV | <input type="checkbox"/> | <input type="checkbox"/> | Irregular Heartbeat | <input type="checkbox"/> | <input type="checkbox"/> |
| Asthma | <input type="checkbox"/> | <input type="checkbox"/> | Stroke | <input type="checkbox"/> | <input type="checkbox"/> | Heart Murmur | <input type="checkbox"/> | <input type="checkbox"/> |
| Emphysema | <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy or Seizures | <input type="checkbox"/> | <input type="checkbox"/> | Angina/Chest Pain | <input type="checkbox"/> | <input type="checkbox"/> |
| Diabetes/ or Hypoglycemia | <input type="checkbox"/> | <input type="checkbox"/> | Glaucoma | <input type="checkbox"/> | <input type="checkbox"/> | Heart Attack | <input type="checkbox"/> | <input type="checkbox"/> |
| Cancer | <input type="checkbox"/> | <input type="checkbox"/> | Blood Transfusion | <input type="checkbox"/> | <input type="checkbox"/> | Chemotherapy | <input type="checkbox"/> | <input type="checkbox"/> |
| Congenital Heart Disorders | <input type="checkbox"/> | <input type="checkbox"/> | Bruise Easily | <input type="checkbox"/> | <input type="checkbox"/> | Mitral Valve Prolapse | <input type="checkbox"/> | <input type="checkbox"/> |
| Stomach/Intestinal Disease | <input type="checkbox"/> | <input type="checkbox"/> | Excessive Bleeding | <input type="checkbox"/> | <input type="checkbox"/> | Rheumatic Fever | <input type="checkbox"/> | <input type="checkbox"/> |
| Tuberculosis | <input type="checkbox"/> | <input type="checkbox"/> | Swelling of Limbs | <input type="checkbox"/> | <input type="checkbox"/> | Artificial Heart Valve | <input type="checkbox"/> | <input type="checkbox"/> |
| Liver Disease | <input type="checkbox"/> | <input type="checkbox"/> | Shortness of Breath | <input type="checkbox"/> | <input type="checkbox"/> | Heart Pace Maker | <input type="checkbox"/> | <input type="checkbox"/> |
| Hepatitis A | <input type="checkbox"/> | <input type="checkbox"/> | Frequent Cough | <input type="checkbox"/> | <input type="checkbox"/> | Heart Surgery | <input type="checkbox"/> | <input type="checkbox"/> |
| Hepatitis B or C | <input type="checkbox"/> | <input type="checkbox"/> | Sinus Problems | <input type="checkbox"/> | <input type="checkbox"/> | Artificial Joint | <input type="checkbox"/> | <input type="checkbox"/> |
| Jaundice | <input type="checkbox"/> | <input type="checkbox"/> | Ulcers | <input type="checkbox"/> | <input type="checkbox"/> | Cosmetic Augmentation | <input type="checkbox"/> | <input type="checkbox"/> |

Have you ever had, or do you have, any other illness or condition not listed? _____

To my knowledge, the information given above is correct and accurate. I will inform the doctor and staff should any changes occur.

Signature: _____ Date: _____