Welcome!

Personal Information

Today's Date_____ Birthdate_____

Name_____ SSN_____

Wish to be called/nickname_____ Employer_____

___Single ___Married ___Visitor Occupation_____

Mailing Address_____

City_____ State_____ Zip_____

Home #_____ Work #_____ Cell #_____

Email Address _____

If minor, name of Parent or Guardian_____
Parent or Guardian's Social Security #_____ Phone #_____
In case of emergency who should be contacted?_____
Relationship_____ Phone #_____

Whom may we thank for referring you?_____

Dental Insurance Information

Name of insured_____ Birthdate_____
Insured SSN_____ Insured ID_____
Insurance Company_____ Address_____
Insurance phone_____
Name of employer_____
Do you have dental secondary insurance?_____

Authorization and Release

I authorize the dentist to release any information including the diagnosis and the records of any treatment or exam rendered to me or my child during the period of such dental care to third party payors and/or other health practitioners. I authorize and request my insurance company to pay directly to Emma L. Gavito, DDS insurance benefits otherwise payable to me. *I understand that my 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.*

Financial Arrangements

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment is appreciated.

Cash___ Check___ Visa___ MC___ AmEx___ Discover___ Care Credit___

Signature of patient, parent or guardian_____ Date_____

Dental History

Name_____ **Date**_____

Reason for today's visit_____

Last dental visit:_____Last professional cleaning:_____
Last x-rays:_____

How often do you brush your teeth?_____floss_____

What texture brush do you use? Soft Medium Hard

Do your gums bleed while brushing?_____flossing?_____
Have you noticed any loosening of your teeth?_____If so, where?_____
Have you noticed a change in your breath?_____
Have you ever had any gum treatments?_____

How important are your teeth to you? _____ Have you ever experienced any of the following problems with your jaw?
_____ Clicking?
_____Pain (joint, ear, side of face)?
_____Difficulty in opening or closing?
_____ Chewing?

Have you had any head, neck, or jaw injuries?_____ if yes, please explain:

_____

Do you have frequent headaches?_____ How Often?_____
Do you take any medication for these headaches?_____
Do you clench or grind your teeth while awake or asleep?_____

Have you ever had orthodontic treatment (braces)?_____oral surgery?____

Are you satisfied with the appearance of your teeth?___ If no, what would you like to change?_____

Medical History

Name_____ **Date**_____

Medical Physician's Name:_____ Phone:_____
Address_____City_____State_____Zip_____

Are you currently under the care of a Physician?_____
Are you taking any medication(s) including non-prescription medication?
_____no
_____yes, please list_____
_____ Are you taking an anticoagulant (blood thinner)? _____
_____ Do you require antibiotics prior to appointment? _____

Have you ever had (please check)

_____Heart trouble
_____Low blood pressure
_____High blood pressure
_____Abnormal bleeding
_____Heart murmur
_____Mitral valve prolapse
_____Rheumatoid arthritis
_____Diabetes
_____Joint replacement
_____Systemic Lupus Erythematosus
_____Radiation treatment
_____Epilepsy/Convulsions
_____Thyroid Problems
_____AIDS/HIV infection
_____Sexually Transmitted Disease
_____Hepatitis
_____Tuberculosis
_____Asthma
_____Emphysema
_____Hemophilia
_____Kidney Disease
_____Glaucoma
_____Stomach ulcer
_____Other_____

Are you allergic to the following?
_____Aspirin _____Penicillin _____Codeine _____Acrylic
_____Latex _____Local anesthetics _____ Other

Do you
_____smoke, if so, how much?_____
_____use smokeless tobacco, if so, how often?_____
_____ drink alcohol ?
_____history of chemical dependency?____ how long in recovery?_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my(or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of patient, parent or guardian _____Date_____