Gonzales Dental Care
851-H 5th St., Gonzales, CA 93926
PH (831) 240-0865
FX (831) 250-6753
www.GonzalesDentalCare.com

Welcome to Gonzales Dental Care!

First Name: _____ MI: _____ Last Name: _____

Address: _____ City: _____ State: ____ ZIP: _____

SSN: _____ DOB: _____ Sex: ☐ Male ☐ Female

Home Phone: _____ Cell Phone: _____ E-mail: _____

Employer: _____ Occupation: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Domestic Partner

How did you hear about our office? _____

Do you prefer to be contacted for appointment confirmation via e-mail, text, or phone? _____

Insurance - Primary

Subscriber Name: _____ Relationship to Patient: _____ Subscriber DOB: _____

Subscriber SSN/ID: _____ Subscriber Employer: _____

Insurance Company Name & Address: _____

Insurance Company Phone: _____ Group Number: _____

Insurance – Secondary

Subscriber Name: _____ Relationship to Patient: _____ Subscriber DOB: _____

Subscriber SSN/ID: _____ Subscriber Employer: _____

Insurance Company Name & Address: _____

Insurance Company Phone: _____ Group Number: _____

Assignment and Release

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to Gonzales Dental Care all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature: _____

Relationship: _____ Date: _____

CONSENT: I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.

Patient/Guardian Signature: _____

Medical History

Do you have a personal physician? ❑ Yes ❑ No

Physician's Name: _____ Physician's Phone: _____Date of Last Visit: _____

Your current physical health is: ❑ Good ❑ Fair ❑ Poor

Are you currently under the care of a physician? ❑ Yes ❑ No

Please explain: _____

Do you use tobacco in any form? ❑ Yes ❑ No

Have you had any metal rods, pins or implants placed? ❑ Yes ❑ No

Are you taking any medications? ❑ Yes ❑ No

Please list each one: _____

Have you ever had any surgical procedures? ❑ Yes ❑ No

Please list each one: _____

Yes	No	Conditions
❑	❑	Abnormal Bleeding
❑	❑	Alcohol Abuse
❑	❑	Allergies
❑	❑	Anemia
❑	❑	Angina Pectoris
❑	❑	Arthritis
❑	❑	Artificial Heart Valve
❑	❑	Asthma
❑	❑	Blood Transfusion
❑	❑	Cancer
❑	❑	Chemotherapy
❑	❑	Colitis
❑	❑	Congenital Heart Defect
❑	❑	Diabetes
❑	❑	Difficulty Breathing
❑	❑	Drug Abuse
❑	❑	Emphysema
❑	❑	Epilepsy
❑	❑	Facial Surgery
❑	❑	Fainting Spells
❑	❑	Fever Blisters
❑	❑	Frequent Headaches

Yes	No	Conditions
❑	❑	Glaucoma
❑	❑	HIV+ AIDS
❑	❑	Heart Attack
❑	❑	Heart Murmur
❑	❑	Heart Surgery
❑	❑	Hemophilia
❑	❑	Hepatitis A
❑	❑	Hepatitis B
❑	❑	Hepatitis C
❑	❑	High Blood Pressure
❑	❑	Joint Replacement
❑	❑	Kidney Problems
❑	❑	Liver Disease
❑	❑	Low Blood Pressure
❑	❑	Mitral Valve Prolapse
❑	❑	Pace Maker
❑	❑	Psychiatric Problems
❑	❑	Radiation Therapy
❑	❑	Rheumatic Fever
❑	❑	Seizures
❑	❑	Sexually Transmitted Disease
❑	❑	Shingles

Yes	No	Conditions
❑	❑	Sickle Cell Disease
❑	❑	Sinus Problems
❑	❑	Stroke
❑	❑	Thyroid Problems
❑	❑	Tuberculosis
❑	❑	Ulcers
Yes	No	**Allergies**
❑	❑	Aspirin
❑	❑	Codeine
❑	❑	Dental Anesthetics
❑	❑	Erythromycin
❑	❑	Jewelry
❑	❑	Latex
❑	❑	Metals
❑	❑	Penicillin
❑	❑	Tetracycline
Yes	No	**If Female, Please Answer**
❑	❑	Are you taking Birth Control Pills?
❑	❑	Are you pregnant? If so, # of Weeks _____
❑	❑	Are you nursing?

Nearest relative not living with you (Name): _____ Relationship: _____

Address: _____ Phone: _____

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 confidence and it is my responsibility to inform this office of any changes in my medical status.

Signature: _____ Date: _____

Dental History

How may we help you today? _____

Your current dental health is: ❑ Good ❑ Fair ❑ Poor

Do you require antibiotics before dental treatment? ❑ Yes ❑ No

Are you currently in pain? ❑ Yes ❑ No

Have you ever had gum treatment? ❑ Yes ❑ No

Do you now or have you had any pain/discomfort in your jaw joint? (TMJ) ❑ Yes ❑ No

Are you under stress? (new job,moving,relationships) ❑ Yes ❑ No

Do you like your smile? ❑ Yes ❑ No

Is there anything you would like to change about your smile? ❑ Yes ❑ No

Are you happy with the color of your teeth? ❑ Yes ❑ No

Do your gums bleed? ❑ Yes ❑ No

How many times a do you: floss/week? _____ brush/day?_____

Are your teeth sensitive to heat, cold or anything else? ❑ Yes ❑ No

Have you lost any teeth? ❑ Yes ❑ No

Have you ever had a serious/difficult problem with any previous dental work? ❑ Yes ❑ No

Have you ever had any unfavorable dental experiences? ❑ Yes ❑ No

When was your last dental cleaning? _____

When was your last dental visit? _____

Why did you leave your previous dentist? _____

How can we accommodate you better during your dental visit? _____

Here at Gonzales Dental Care we offer a wide variety of services to enhance and keep your smile beautiful. Please circle any services below you would like our friendly staff to discuss with you during your visit.

Teeth Whitening	**Smile Makeover**	**Implant Crowns**
Veneers/Lumineers	**Bonding**	**Partials/Dentures**
Invisalign	**Sealants**	**Night/Sport Guards**
Traditional Orthodontics (Brackets)	**Crown and Bridge**	