# WELCOME

The benefits of a happy and healthy smile are immeasurable!
Our goal at Dr. Garcia and Dr. Sanchez-Garcia's practice is to help you reach and maintain maximum oral health. Please fill out this form completely. The better we communicate, the better we can care for you.

## PERSONAL

TITLE ☐Mr. ☐Mrs. ☐Ms. ☐Miss ☐Dr. ☐Rev. ☐None

NAME ____________________
FIRST MI LAST

(H) ADDRESS ____________________

____________________
CITY STATE ZIP

(H) PHONE (___) ____________________

(W) PHONE (___) ____________________

Mobile (___) ____________________

EMAIL ADDRESS ____________________

SOCIAL SECURITY # ____________________

DRIVER LICENSE ____________________

BIRTHDATE ____________________

SEX ☐Male ☐Female

MARITAL STATUS ☐Married ☐Single ☐Divorced ☐Widowed

## EMPLOYER ____________________

(W) ADDRESS ____________________

____________________
CITY STATE ZIP

OCCUPATION ____________________

HOW LONG HAVE YOU BEEN EMPLOYED THERE _____

Whom may we thank for referring you?

____________________

Previous Dentist ____________________

Last Dental Visit ____________________

## SPOUSE

TITLE ☐Mr. ☐Mrs. ☐Ms. ☐ Miss ☐Dr. ☐Rev. ☐None

NAME ____________________
FIRST MI LAST

EMPLOYER ____________________

(W) ADDRESS ____________________

____________________
CITY STATE ZIP

(W) PHONE (___)____________________

SOCIAL SECURITY # ____________________

BIRTHDAY ____________________

## INSURANCE

NAME ____________________

ADDRESS ____________________

____________________
CITY STATE ZIP

PHONE (___)____________________

GROUP # ____________________

INSURED 'S NAME ____________________

SOCIAL SECURITY____________________

BIRTHDAY ____________________

EMPLOYER ____________________

DO YOU HAVE AN ADDITIONAL INSURANCE? ☐ YES ☐ NO

NAME ____________________

ADDRESS ____________________

____________________
CITY STATE ZIP

GROUP # ____________________

IF YES, PLEASE COMPLETE THE FOLLOWING:

INSURED 'S NAME ____________________

SOCIAL SECURITY____________________

BIRTHDAY ____________________

EMPLOYER ____________________

I have reviewed the following treatment plan. I authorize release of any information this claim. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL COSTS OF DENTAL TREATMENT.

I hereby authorize payment directly to the above named relating to dentist of the group insurance benefits otherwise payable to me.

_X____________________ ____________________
SIGNED (PATIENT OR PARENT IF MINOR) DATE

_X____________________
SIGNED (INSURED PERSON) DATE

HIPAA PRIVACY: ____________________
SIGNED

# HEALTH HISTORY ____________________________________________

Although Drs. Garcia and Sanchez–Garcia primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have or medications that you may be taking could have an important interrelationship with the dentistry that you will be receiving. Thank you for answering the following questions.

Today's Date _____________

Name ______________________________________ Birthday __________ Age ______________
Why are you now seeking dental treatment? ____________________________________________

1. Do you have or ever had any of the following?

| | Yes | No |
|---|---|---|
| **NERVOUS SYSTEM** | | |
| Stroke | ____ | ____ |
| Epilepsy/Seizures | ____ | ____ |
| Psychiatric treatment | ____ | ____ |
| Panic Attacks | ____ | ____ |
| Depression | ____ | ____ |
| **ENDOCRINE** | | |
| Diabetes | ____ | ____ |
| Thyroid condition/ Goiter | ____ | ____ |
| **RESPIRATORY** | | |
| Tuberculosis | ____ | ____ |
| Emphysema | ____ | ____ |
| Asthma/ hay fever | ____ | ____ |
| Sinus problems | ____ | ____ |
| **DIGESTIVE SYSTEM** | | |
| Hepatitis | ____ | ____ |
| Ulcers | ____ | ____ |
| **BLOOD** | | |
| Bruise easily | ____ | ____ |
| Anemia | ____ | ____ |
| Blood Transfusion | ____ | ____ |
| Hemophilia | ____ | ____ |

| | Yes | No |
|---|---|---|
| **CARDIOVASCULAR** | | |
| Rheumatic Fever | ____ | ____ |
| Heart murmur | ____ | ____ |
| Chest Pain/Discomfort | ____ | ____ |
| Heart attack/trouble | ____ | ____ |
| Shortness of breath | ____ | ____ |
| High blood Pressure | ____ | ____ |
| Congenital heart disease | ____ | ____ |
| Mitral valve prolapse | ____ | ____ |
| Artificial heart valve | ____ | ____ |
| Pacemaker | ____ | ____ |
| Heart Surgery/surgical stent | ____ | ____ |
| **BONE/MUSCLE** | | |
| Arthritis/rheumatism | ____ | ____ |
| Artificial joints/limbs | ____ | ____ |
| Osteoporosis | ____ | ____ |
| **OTHER** | | |
| TMJ Pain | ____ | ____ |
| Radiation therapy | ____ | ____ |
| Chemotherapy | ____ | ____ |
| Cancer/Tumor | ____ | ____ |
| HIV + or AIDS | ____ | ____ |
| Venereal disease | ____ | ____ |

2. List any allergic reactions to medicine, detergents, or herbal remedies.
   ______________________________________________________________
3. Please give the name and the dosage of ANY MEDICINE with or without a prescription, or herbal remedies you are now taking.
   ______________________________ ________________________________
   ______________________________ ________________________________

4. Are you currently taking any medicine for osteoporosis such as: Fosamax, Boniva, Actonel, Zometa, or Aredia. If so, for how long ____________________________________.
5. (Women) Are you pregnant? If so, give the due date____________________.
6. Do you use tobacco in any form?_________ If yes, how much per day and for how long? _____________
7. Is there any disease, condition, or problem not listed above that you think we should know about?
______________________________________________________________________________
8. Have you ever had? – Heavy bleeding following a tooth extraction ____________.
– Any serious problems following a dental procedure.____________.

**Please complete reverse side**

If yes, please explain ___________________________________________________________

9. Does dental treatment make you nervous? No___ Slightly ____ Moderately____ Extremely______

10. Check your level of dental anxiety: Mild Moderate Severe

11. Physician's name ____________________________ Phone______________________

12. Date of last dental visit_________________________

13. Please check any topic below you would like to know more about:

| | |
|---|---|
| ____Implants | ____Facial Rejuvenation |
| ____Periodontal therapy (Gum treatment) | ____Botox |
| ____Smile makeover | ____Sedation dentistry |
| ____Veneers | ____Night guard for TMJ/Migraine therapy |
| ____Crowns | ____Restylane/ Perlane |
| ____Wisdom teeth extractions | ____Juvederm/ Juvederm Ultra |
| ____Athletic mouth guards | ____ Smoking Cessation |
| ____Tooth Whitening | ____INVISALIGN orthodontic treatment |

To the best of my knowledge, all of the preceding answers are true and correct. If ever I have any change in my health or medication, I will inform Dr. Garcia or Dr. Sanchez-Garcia at my next appointment.

Signature of Patient
Signature or Guardian______________________________ Date___________________________

I authorize Drs. Garcia and Sanchez-Garcia as he/she may select to photograph me. I understand the photograph will be used only for medical and educational purpose and will not be released for publication in any other context without my expressed written consent.

Signature ____________________________________

## DENTAL PHOTO RELEASE

Your photos are part of your diagnostic and clinical record. We make use of radiographs, photographs, and digital images. These images may be used for diagnosis, documentation, reference, teaching, and research publication. Some cases that present exceptional results, particularly remarkable smiles, or interesting situations may be utilized for demonstration, education or advertising to potential and existing patients in our office either in print media, television, on digital media and on our webpage. In some instances, you may be recognizable in some of these images.

By initialing and signing this form, you are authorizing us and releasing us from any liability resulting from the use of such images. Your authorization and release to use images will in no way affect the quality of your results in our office. We do our best to provide exceptional dentistry to all patients.

***Please Initial All Items Below That Apply:***

___________ I authorize the use of all images.

___________ I authorize the use of images where my face is not identifiable.

___________ Store images in my diagnostic record only.

This authorization will remain in effect until cancelled. Any future cancellation will not affect the usability of images that have already been released. I have read and understand this form.

Signature ______________________________ Date: _____________________

Print Name (Parent, if patient is a minor)

_____________________________________________

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**FINANCIAL ARRANGEMENTS AND DENTAL INSURANCE**

We are committed to providing you with the best possible care. If you have dental insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance, and your understanding of our payment policy.

Payment for services is due at the time services are rendered. If you have insurance you will pay your deductible, if applicable, and any portion we estimate your insurance will not pay. If you do not have insurance, then you will pay your balance unless our staff had previously approved payment arrangements. We accept cash, checks, Master Card, Visa, American Express, Discover, Dental Fee Plan and Care Credit. Care Credit is a dental credit card you can apply for. Dental Fee Plan is a payment plan. Please ask for more details if interested as this may offer you a payment plan with no interest for up to 12 months. We will be happy to help you process your insurance claim form and we generally accept assignment of insurance benefits for their portion of covered services.

We gladly accept your checks. When you provide a check as payment, you authorize us to use information from the check to make a one-time electronic fund transfer from your account, or to process the payment as a check transaction. You authorize us to collect a fee ($25 for checks $50 or less. $30 for checks greater than $50 and less than $300. $40 or 5% of face if amount greater than $300. Plus a bank fee if allowable by state law) through electronic fund transfer from your account if your payment is returned unpaid. Balances older than 30 days may be subject to additional collection fees and interest charges of 1.5% per month. Charges may also be made for broken appointments and appointments canceled without 24 hours notice.

We will gladly discuss your proposed treatment and answer any questions relating to your dental insurance.

You MUST realize, however, that:

1. Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract.
2. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

We must emphasize that as dental care providers, our relationship is with you and not your insurance company. While the filing of insurance claims is a courtesy we extend to our patients, all charges are your responsibility from the date the services are rendered.

If you have any questions about the above the information or any uncertainty regarding insurance coverage, PLEASE do not hesitate to ask us. We are here to help you.
Whom may we contact in the case of an emergency:

Name______________________________________ Telephone_______________________________

I understand and agree that in the event this office must go to an outside firm to collect the amount I owe, I will be expected to pay all costs for such actions, including reasonable attorney's fees.
I understand and agree that I am ultimately responsible for the balance of my account for any professional services rendered.
I have read all the information on this form and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my health status or the above information.

Signature______________________________________ Date_________________________________