

# 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

## SPOUSE

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

NAME \_\_\_\_\_  
FIRST MI LAST

EMPLOYER \_\_\_\_\_

(W) ADDRESS \_\_\_\_\_  
CITY STATE ZIP

## INSURANCE

NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_  
CITY STATE ZIP

PHONE (\_\_\_\_) \_\_\_\_\_

GROUP # \_\_\_\_\_

DO YOU HAVE AN ADDITIONAL INSURANCE?  YES  NO

NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_  
CITY STATE ZIP

GROUP # \_\_\_\_\_

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 \_\_\_\_\_

(W) PHONE (\_\_\_\_) \_\_\_\_\_

SOCIAL SECURITY # \_\_\_\_\_

BIRTHDAY \_\_\_\_\_

INSURED 'S NAME \_\_\_\_\_

SOCIAL SECURITY \_\_\_\_\_

BIRTHDAY \_\_\_\_\_

EMPLOYER \_\_\_\_\_

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.

X \_\_\_\_\_  
SIGNED (PATIENT OR PARENT IF MINOR)

DATE

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

X \_\_\_\_\_  
SIGNED (INSURED PERSON)

DATE

HIPAA PRIVACY: \_\_\_\_\_  
SIGNED

# HEALTH HISTORY

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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		Yes	No
<b>NERVOUS SYSTEM</b>			<b>CARDIOVASCULAR</b>		
Stroke .....	_____	_____	Rheumatic Fever.....	_____	_____
Epilepsy/Seizures.....	_____	_____	Heart murmur.....	_____	_____
Psychiatric treatment.....	_____	_____	Chest Pain/Discomfort.....	_____	_____
Panic Attacks.....	_____	_____	Heart attack/trouble.....	_____	_____
Depression.....	_____	_____	Shortness of breath.....	_____	_____
<b>ENDOCRINE</b>			High blood Pressure.....		
Diabetes.....	_____	_____	Congenital heart disease.....		
Thyroid condition/ Goiter.....	_____	_____	Mitral valve prolapse.....		
<b>RESPIRATORY</b>			Artificial heart valve.....		
Tuberculosis.....	_____	_____	Pacemaker.....		
Emphysema.....	_____	_____	Heart Surgery/surgical stent.....		
Asthma/ hay fever.....	_____	_____	<b>BONE/MUSCLE</b>		
Sinus problems.....	_____	_____	Arthritis/rheumatism.....		
<b>DIGESTIVE SYSTEM</b>			Artificial joints/limbs.....		
Hepatitis.....	_____	_____	Osteoporosis.....		
Ulcers.....	_____	_____	<b>OTHER</b>		
<b>BLOOD</b>			TMJ Pain.....		
Bruise easily.....	_____	_____	Radiation therapy.....		
Anemia.....	_____	_____	Chemotherapy.....		
Blood Transfusion.....	_____	_____	Cancer/Tumor.....		
Hemophilia.....	_____	_____	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. Circle 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:

- |  |   |
|--|---|
| <input type="checkbox"/> Implants                            | <input type="checkbox"/> Facial Rejuvenation                  |
| <input type="checkbox"/> Periodontal therapy (Gum treatment) | <input type="checkbox"/> Botox                                |
| <input type="checkbox"/> Smile makeover                      | <input type="checkbox"/> Sedation dentistry                   |
| <input type="checkbox"/> Veneers                             | <input type="checkbox"/> Night guard for TMJ/Migraine therapy |
| <input type="checkbox"/> Crowns                              | <input type="checkbox"/> Restylane/ Perlane                   |
| <input type="checkbox"/> Wisdom teeth extractions            | <input type="checkbox"/> Juvederm/ Juvederm Ultra             |
| <input type="checkbox"/> Athletic mouth guards               | <input type="checkbox"/> Smoking Cessation                    |
| <input type="checkbox"/> Tooth Whitening                     | <input type="checkbox"/> 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:***

- |       |   |
|-------|---|
| _____ | <input type="checkbox"/> I authorize the use of all images.                               |
| _____ | <input type="checkbox"/> 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)

\_\_\_\_\_

**Raul I. Garcia, D.M.D.**  
**Concepcion M. Sanchez-Garcia, D.M.D.**

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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 \_\_\_\_\_