

Date: _____

Name: _____ Birthdate: _____

Mailing address: _____ City: _____ State: _____ Zip: _____

Home phone: _____ Cell phone: _____ Work phone: _____ Email: _____

Sex: M F Marital status: Single Married Divorced Separated Partnership Minor

Employer or School: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Spouse, partner or parent name: _____

Person to contact in case of an emergency: _____ Phone: _____

How did you learn about us or whom may we thank for referring you? _____

Who is responsible for your account and payment? (if different from previous listing): _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Email: _____ Birthdate: _____

Insurance information Insurance company: _____ Phone # _____

Subscriber's Social Security # _____ Group # _____ ID # _____

Address: _____ City: _____ State: _____ Zip: _____

How much is your deductible? _____ How much have you used? _____ What is your annual maximum benefit? _____

Whose name is this insurance under? _____

Employer offering this insurance? _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Secondary dental insurance Insurance company: _____ Phone # _____

Dr Sebastian reserves the right to not submit for secondary insurance and will provide you with documentation to do this.

Your Social Security # _____ Group # _____ ID # _____

Address: _____ City: _____ State: _____ Zip: _____

How much is your deductible? _____ How much have you used? _____ What is your annual maximum benefit? _____

Whose name is this insurance under? _____

Employer offering this insurance? _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Dental history

Reason for today's visit: _____

Date of last dental care visit: _____ Date of last dental x-rays: _____

Former dentist's name: _____ Address: _____ City: _____ State: _____ Zip: _____ Phone: _____

Check if you have any problem with the following:

- | | | |
|--|--|---|
| <input type="checkbox"/> Bad breath | <input type="checkbox"/> Food collection between certain teeth | <input type="checkbox"/> Periodontal treatment |
| <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Grinding teeth | <input type="checkbox"/> Sensitivity to any of the following: cold, hot, sweets, biting |
| <input type="checkbox"/> Clicking or popping jaw | <input type="checkbox"/> Loose teeth or broken fillings | <input type="checkbox"/> Sores or growth in your mouth |

How often do you floss? _____ How often do you brush? _____

Medical History

Your physician: _____ Date of last visit _____

Have you ever taken any of the groups of drugs collectively referred to as "fen-phen"? These include combinations of loimin, Adipex, Fastin (brand name of phentermine) Pondimin (fenfluramine) and Redux (dexfenfluramine). Yes No

Have you had any serious illnesses or operations? Yes No

If yes, describe: _____

Have you ever had a blood transfusion? Yes No

If yes, give approximate dates: _____

Women: are you pregnant? Yes No

Are you nursing? Yes No

Are you taking birth control? Yes No

Check if you have or have had any of the following:

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Circulatory problems | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Arthritis, rheumatism | <input type="checkbox"/> Congenital heart lesions | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Scarlet fever |
| <input type="checkbox"/> Artificial heart valves | <input type="checkbox"/> Diabetes | <input type="checkbox"/> HIV AIDS | <input type="checkbox"/> Sexually transmitted disease |
| <input type="checkbox"/> Artificial joints, pins, etc. | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Jaw pain | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fainting | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Swelling of feet or ankles |
| <input type="checkbox"/> Bleeding abnormally | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Blood disease | <input type="checkbox"/> Headaches | <input type="checkbox"/> Mitral valve prolapse | <input type="checkbox"/> Tobacco use |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Chemical dependency | <input type="checkbox"/> Heart problems | <input type="checkbox"/> Radiation treatment | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Respiratory disease | <input type="checkbox"/> Ulcer |

List medications you are currently taking and the correlating diagnosis: _____

Allergies: _____

Authorization

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I or my minor child has a change in health.

I certify that I and/or my dependent/s have insurance coverage with _____ and assign directly to Dr. Sebastian Gonzales 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 my insurance. I authorize the use of my signature on all insurance submissions.

Dr. Sebastian may use my health care information and may disclose such information to my insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefit payable for related services. This consent will continue as long as I am a patient with Dr. Sebastian.

Signature of patient (parent, guardian or person representative) _____ Date: _____

Print name of patient (parent, guardian or person representative) _____ Date: _____

Payment is due at the time of services unless prior arrangements have been made and approved.
