SYLVIA MARTINEZ, D.D.S.

Family & Cosmetic Dentistry in San Antonio, Texas

Patient Information Form

Personal Information

Todays date: ___/___/___ File#: _____

Patient Name: _____
LAST FIRST MI

What you prefer to be called: _____ ☐ Male ☐ Female

Birthdate: ___/___/___ Age: _____ SS#: _____

Mailing Address: _____

_____
CITY STATE ZIP

Home Phone: (___) _____

Work Phone: (___) _____

Cell Phone: (___) _____

Email Address: _____

Referred By: _____

Employer: _____ How long? _____

Employer's Address: _____

_____
CITY STATE ZIP

Occupation: _____

Status: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Spouse's Name: _____

Insurance Information

Primary Dental Care

Co. Name: _____

Address: _____

_____
CITY STATE ZIP

Phone: (___) _____

Insured's ID#: _____

Relation: _____ Date of Birth: ___/___/___

Insured's Employer: _____

Secondary Dental Care

Co. Name: _____

Address: _____

_____
CITY STATE ZIP

Phone: (___) _____

Insured's ID#: _____

Relation: _____ Date of Birth: ___/___/___

Insured's Employer: _____

Account Information

Person Ultimately Responsible for Account

Name: _____

Relation: _____

Billing Address: _____

_____
CITY STATE ZIP

SS#: _____

Drivers License #: _____

Work phone #: (___) _____

Payment Method: ☐ Cash ☐ Check

☐ Credit Card - enter # if accepted: _____

_____
Initials

I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am soley responsible for any balance not paid by my insurance comapny (if not offered by this office).

In Event of Emergency

Whom should we contact? _____

Relation _____

Home Phone: (___) _____

Work Phone: (___) _____

Cell Phone: (___) _____

Who's your medical doctor? _____

Medical Doctors Phone: (___) _____

Dental Information

Reason for todays visit: ☐ Exam ☐ Emergency ☐ Consultation

Are you in pain? ☐ No ☐ Yes How Long? _____

Please Indicate any of the following problems:

☐ Discomfort, clicking or popping of jaw ☐ Lost/Broken Fillings ☐ Stained Teeth

☐ Red, swollen, or bleeding gums ☐ Teeth grinding ☐ Locking Jaw

☐ Sensitive Tooth, teeth, or gums ☐ Ringing in Ears ☐ Bad Breath

☐ Blisters/Sores in or around the mouth ☐ Broken/chipped tooth

☐ Other: _____

Do you require pre-medication? ☐ No ☐ Yes ☐ Don't Know

Previous Dentist: _____ (_____) _____

Name Phone #

Last Dental Exam: ____/____/____ Last Dental X-rays: ____/____/____

Times a day you brush: _____ Times a day you floss: _____

How Would you rate your smile?: (worst) 1 2 3 4 5 6 7 8 9 10 (best)

Medical History

What Medications are you taking?: ☐ Nerve Pills ☐ Pains Killers (including aspirin) ☐ Muscle relaxers

☐ Stimulants ☐ Blood thinners ☐ Tranquilizers ☐ Insulin ☐ Meds for Osteoporosis

☐ Other: _____

Do you have any of the following diseases, medical conditions or procedures?

Y N Heart Attack/Stroke	**Y N** Thyroid Problems	**Y N** Cancer/Tumors	**Y N** Cosmetic Surgery
Y N Heart Surg./Pacemaker	**Y N** Kidney Problems	**Y N** Shingles	**Y N** Xray or Cobalt Treatment
Y N Heart Murmur	**Y N** Liver Problems	**Y N** Hepatitis	**Y N** Chemotherapy
Y N Rheumatic Fever	**Y N** Respiratory Problems	**Y N** HIV/AIDS/ARC	**Y N** Athsma
Y N Mitral Valve Prolapse	**Y N** Sinus Problems	**Y N** Arthritis/Rheumatism	**Y N** Difficulty Breathing
Y N Artificial Valves	**Y N** Stomach Problems / Ulcers	**Y N** Artificial Bones/Joints	**Y N** Diabetes/Hypoglycemia
Y N Heart Disease	**Y N** Psychiatric Problems	**Y N** Emphysema	**Y N** Leukemia
Y N Congenital Heart Defect	**Y N** Venereal Disease	**Y N** Fainting/Seizures/Epilepsy	**Y N** Anemia
Y N Chest Pains	**Y N** Alcohol/Drug Abuse	**Y N** Severe/Frquent Headaches	**Y N** High/Low Blood Pressure
Y N Scarlet Fever	**Y N** Tuberculosis TB	**Y N** Frequent Neck Pain	**Y N** Bleeding Problems
Y N Nervousness	**Y N** Jaw Problems TMJ / TMD	**Y N** Back Problems	**Y N** Glaucoma

Please list any other surgeries or medical conditions you have or ever had _____

_____

Are you allergic to any of the following? ☐ Latex ☐ Penicillin / Amoxicillin ☐ Tetracycline ☐ Aspirin

☐ Dental Anesthetics ☐ Other: _____

Do you use tobacco? ☐ No ☐ Yes For women: Are you pregnant? ☐ No ☐ Yes/How long? _____

We invite you to discuss with us any questions regarding our services. The best dental health services are based on a friendly, mutual understanding between provider and patient.

Our Policy requires payment in full for all our services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.

I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims

I understand the above information and gaurantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any charges to the information I have provided

_____ I acknowledge that I have received a copy of the summary of the Privacy Notice

Initials

Signature: _____ **Date:** ____/____/____

Employee Signature: _____ **Date:** ____/____/____