**Hill Country Dental Maria C. Garanzuay, DDS, PC**

*20770 US 281N. #110 4932 Windsor Hill*

*San Antonio, TX 78258 San Antonio, TX 78239*

*Phone: 210-494-4455 Phone: 210-653-4410*

**Patient Information**

Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name you wish to be called: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physical Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street Name and # City Zip code

Mailing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street Name and # or PO Box City Zip code

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Circle one*:*** Single Married Widowed Separated Divorced **Sex**: Male Female  **Age**: \_\_\_\_\_ **Birth date**: \_\_\_\_\_\_\_\_\_\_

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patients Social Sec. # \_\_\_\_\_\_\_\_\_\_\_\_

Employer Address and phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Spouse Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Spouse Birth date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Sec. # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Spouse Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Spouse’s Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**IN CASE OF EMERGENCY PLEASE CONTACT (someone NOT living with you)**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to you: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone numbers (home and cell): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*\*\*\*\*If you gave us a copy of your insurance card there is no need to fill this part out\*\*\*\*\***

Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insurance Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of policy holder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy holders Social Security #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy holders birth date #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is the patient covered by a secondary insurance: **Yes / No** ***If yes, continue***:

Name of Secondary Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insurance Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of policy holder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy holders Social Security #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy holders birth date #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ASSIGNMENT AND RELEASE:**

I certify that I (or my dependent) have insurance coverage with the company listed above and authorize my insurance company to pay to the dentist all insurance benefits 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 payment of benefits. I authorize the use of this signature on all insurance submissions.

**\*\*\*Responsible Party Signature**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

*\*\*Who may we thank for referring you: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ If no referring person how did you hear about us*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Patient Name****: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* ***Date of Birth****: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

**Dental History**

**Reason for today’s visit:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Former Dentist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of last dental visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Please circle Yes or No:***

Are your teeth sensitive? YES NO Do you have any jaw problems? YES NO

*If yes, circle to which: If yes, circle which:*

cold hot sweets sour foods biting clicking popping pain difficult to open or chew

Do you have bad breath? YES NO Have you ever had braces? YES NO

Do you have dry mouth? YES NO Do you grind or clinch your teeth? YES NO

Have you ever had gum treatment? YES NO Do you have frequent headaches? YES NO Do your gums bleed? YES NO

Do you have any loose teeth? YES NO Have you been diagnosed w/ sleep apnea? YES NO

Have you ever had any difficult extractions? YES NO Have you been sedated for dental work? YES NO

Do you have any difficulty getting numb? YES NO

Have you had a serious problem with dental treatment? Do you like your smile? YES NO

YES NO *If no, please explain*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other dental issues not listed above YES NO

*Please explain*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICAL INFORMATION:**

Primary Physician’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Of Last Physical: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pharmacy Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Medical History**

***Patient Name****: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* ***Date of Birth****: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

**Health problems that you may have and medications that you may be taking could have interactions with certain dental treatment. Please answer the following to the best of you knowledge.**

Please circle yes or no to indicate if you have or if you ever have had any of the following:

Anemia YES NO Abnormal Bleeding YES NO Arthritis YES NO

Congenital Heart Lesions YES NO Blood Disease YES NO Cortisone Treatments YES NO

Rheumatic Fever YES NO HIV YES NO Asthma YES NO

Heart Murmur YES NO AIDS YES NO Other Respiratory Issues YES NO

Heart Attack YES NO Hepatitis YES NO Stroke YES NO

If Yes, Year: \_\_\_\_\_ If Yes, Type\_\_\_\_\_\_\_ If Yes, Year: \_\_\_\_\_\_

Artificial Heart Valves YES NO Jaundice YES NO Scarlet Fever YES NO

Other Heart Conditions YES NO Psychiatric Care YES NO Thyroid Problems YES NO

High Blood Pressure YES NO Nervous Problems YES NO Tuberculosis YES NO

Low Blood Pressure YES NO Epilepsy YES NO Kidney Disease YES NO

Mitral Valve Prolapse YES NO Fainting YES NO Liver Disease YES NO

Cardiac Pacemaker YES NO Vertigo YES NO Special Diet YES NO

Angina (Chest Pains) YES NO Diabetes YES NO Stomach Trouble YES NO

Cancer YES NO Glaucoma YES NO Herpes YES NO

Chemotherapy YES NO Head/Neck/Mouth Tumors YES NO Artificial Joint YES NO

Radiation Therapy YES NO **Hospital Stays** YES NO Replacement Joints YES NO

If yes, explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Circle medicine you have taken*** Bisphosphonates- Recreational drugs YES NO **FOR WOMEN:**

Fosamax -Boniva - Actonel Controlled legal drugs YES NO Are you pregnant YES NO

-Viagra -Cialis -Levitra -Revati If yes, due date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Nursing? YES NO

Birth control pills YES NO

**Do you have any other conditions or illnesses not listed here YES NO**

If yes, please list/explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**LIST MEDICATION CURRENTLY TAKEN CIRCLE ANY ALLERGIES YOU**

**\*\*\*type none if not taking medications\*\*\***  **\*\*\* (Circle none if no allergies)\*\*\***

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Aspirin Local anesthetic Penicillin

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Codeine Sulfa Iodine

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Latex Metals Sedative

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ None

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. **I understand that it is my responsibility to notify the attending dentist of any changes to my medical status (conditions, allergies, and medications)**

Patient’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Doctor’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_