MEDICATIONS

Date:_____

*** It is very important that we know **ALL** medications you are taking (prescribed and over the counter) Please list them below:

_____ _____ _____

_____ _____ _____

_____ _____ _____

*** Pharmacy you usually go to:_____

PATIENT INFORMATION

Welcome to our office! To assist us in serving you, please complete the following confidential form. The information provided is important to your dental health.

Patient's name _____ Preferred name _____ Birth date _____

If minor, parents names _____ Home phone _____ Work phone _____

Mailing address _____ City _____ State _____ Zip _____

Employer _____ Occupation _____

Spouse's name _____ Spouse's employer _____ ❑ Unmarried

Whom may we thank for referring you to our office? _____ ❑ Phonebook

BILLING, CREDIT, AND INSURANCE INFORMATION: ❑ Not covered by dental insurance

Your Social Security number: _____ Dental Insurance Co. _____ Group number _____

Covered by spouse's insurance? ❑ yes ❑ no

Spouse's dental insurance company _____ Group number _____

Spouse's birthday _____ Social Security number _____

MEDICAL HEALTH HISTORY

Do you have or have you had any of the following?
(Please check any that apply)

- ❑ Cancer or tumor
- ❑ Heart ailment or angina
- ❑ Heart murmur, mitral valve prolapse, heart defect
- ❑ Rheumatic fever or rheumatic heart disease
- ❑ Artificial joint or valve
- ❑ High or low blood pressure
- ❑ Pacemaker
- ❑ Tuberculosis or other lung problems
- ❑ Kidney disease
- ❑ Hepatitis or other liver disease
- ❑ Alcoholism
- ❑ Blood transfusion
- ❑ Diabetes
- ❑ Neurologic condition
- ❑ Epilepsy, seizures, or fainting spells
- ❑ Emotional condition
- ❑ Arthritis
- ❑ Herpes or cold sores
- ❑ AIDS or HIV positive
- ❑ Migraine headaches or frequent headaches
- ❑ Anemia or blood disorders
- ❑ Abnormal bleeding after extractions, surgery, or trauma
- ❑ Hayfever or sinus trouble
- ❑ Allergies or hives
- ❑ Asthma

Do you smoke or use chewing tobacco? ❑ yes ❑ no

Are you allergic to, or have you reacted adversely to any of the following?

- ❑ Latex materials
- ❑ Penicillin or other antibiotics
- ❑ Local anesthetics ("Novocain")
- ❑ Codeine or other narcotics
- ❑ Sulfa drugs
- ❑ Barbiturates, sedatives, or sleeping pills
- ❑ Aspirin
- ❑ Other: _____

Are you taking any of the following?

- ❑ Aspirin
- ❑ Anticoagulants (blood thinners)
- ❑ Antibiotics or sulfa drugs
- ❑ High blood pressure medicine
- ❑ Antidepressants or tranquilizers
- ❑ Insulin, Orinase, or other diabetes drug
- ❑ Nitroglycerin
- ❑ Cortisone or other steroids
- ❑ Osteoporosis (bone density) medicin(Injections)
- ❑ Other: _____

Women:

- ❑ May be pregnant
  Expected delivery date: _____
- ❑ Taking hormones or contraceptives

Name of your physician: _____

Do you have any disease, condition, or problem not listed above? _____

Please add anything else you would like us to know about: _____

Signature of patient (or parent) _____ Date _____

***List any medications you are currently taking on the back of this page

Raphael Guerra D.D.S.
7318 W. Military Drive
San Antonio, Texas 78227

I, _____, consent to be a patient at the above named office and agree to a radiographic and clinical examination. **I also understand and consent to the following:**

1. During the course of treatment, I may undergo procedures in all phases of dentistry including periodontics (gum treatment and surgery), oral surgery, endodontics (root canals), fixed and removable prosthodontics (crowns, bridges, and dentures), implant dentistry, restorative dentistry, temporomandibular disorder treatment, sleep apnea treatment, oral pathology, pediatric dentistry, and radiography.

2. I will provide a thorough and complete medical history, supply a full list of my medications with dosages, and consent to my dentist communicating with my other medical practitioners to inquire about any aspect of my health history.

3. No guarantees can be made about treatment outcomes, restoration longevity, or prognoses. I understand that any branch of medicine, including dentistry, can involve unanticipated results.

4. I will pay in full any cost of treatment or insurance copayments according to the office's financial policy. I understand that even if an insurance preestimate is given or a procedure has been preapproved, I am responsible for *any* costs that my insurance does not cover.

5. My treatment plan may change at any time and I will do my best to approach my dental care with optimism and open communication with my dentist, hygienist, and dental office staff.

6. I am welcome to ask questions about any aspects of my dental care and will request information if I am confused or need more information. I am responsible for clarifying any aspects of my treatment that I am unsure about.

_____ _____
Patient or Guardian Name Date

_____ _____
Witness Date

Raphael Guerra D.D.S
7318 W. Military Dr
San Antonio, Texas 78227
(210)673-1561

Appointment Cancellation Policy

A dental appointment at our clinic is viewed as a commitment and connection between the dental professional and the patient.

Cancellation Policy

Fees for missed appointments:

There is a $30.00 fee for missed appointments without a 24 hour notice. There is a $60.00 fee for missed appointments with our Endodontist (Root canal specialist) We always call a day prior to confirm your appointment. **48 Hour advance cancellation is *preferred* and 24 is *required*.**

If you are unable to keep your appointment, please notify us as soon as possible. Answering machine is on 24 hours a day. When you break your appointment, we are not able to fill the empty spot *(Unless, at least 24 notice is given)*. As time and space is limited someone else may not be able to be seen by us. We value your time, so please value ours as well.

Please arrive 5-10min before your appointment so you can relax and we can update your information. Our clinic in turn will do our best to minimize your waiting time. Those who are more than 15 minutes late will have to reschedule, so the next patients won't have to wait.

After **3** cancelled appointments our office has the right to refuse to make you any other scheduled appointments.

**** If your schedule is hectic or you are NOT sure if you can keep your appointment, then you can schedule it on the same day of treatment (if availability schedule permits).*

_____ **Patient/Guardian Initial**