PATRICIA CUERVO-GARNER, D.D.S
JAMES B. GARNER, D.D.S

PATIENT INFORMATION					
First M.I. Last			How do you prefer to be called?	Patient's Soc. Sec.#	
Address			City	State	Zip Code
Home Phone #	Cell Phone #		Work Phone #	Date of Birth	Age
Employer name			Referred by		
Emergency contact person			Phone # and Relationship		

Sex M□ F□ Single □ Married □ Divorced □ Widowed □ Separated □ Other □

INSURANCE INFORMATION		
Primary Dental Insurance		Insurance ID #
Employer/Insurer Name	Phone #	Group/Policy #

POLICY HOLDER INFORMATION (if other than patient)				
First M.I. Last		Relationship to patient	Policy Holder Soc. Sec. #	
Address		City	State	Zip Code
Home Phone #	Cell Phone #	Work Phone #	Date of Birth	Age

RESPONSIBLE PARTY (if other than Patient or Policy Holder)				
First M.I. Last		Relationship to patient	Social Security #	
Address		City	State	Zip Code
Home Phone	Cell Phone #	Work Phone #	Date of Birth	Age

FINANCIAL AGREEMENT

Thank you for selecting our dental office. Please read the following and sign at the bottom. Payment in full is required at the time of service. For your convenience we accept check, cash, Visa, and Mastercard. Please note that filing your insurance claim and wating for your insurance payment is a courtesy that we offer our patients. We have no control over your insurance policy. The entire fee for your treatment is your responsibility if your insurance company chooses not to cover the treatment. We reserve the right to charge $25 for a returned check, and $20 rebilling fee on accounts thirty days past due. Collection costs, legal fees, and court costs will be also your responsibility if failing to pay in a timely maner. If an appointment needs to be cancelled or rescheduled for any reason please notify our office 24 hours in advance of the day of your appointment. If a patient fails to keep an office visit, a broken/no-show appointment fee of $25 to $75 will be charged, depending on the lenght of the appointment.

If patient is a minor, can you make the legal decisions for this child ? □ YES □ NO

Signature of Patient or Parent/ Legal Guardian	Date

For Office Use Only

MEDICAL UPDATE

No Change	Change	List	Date	Patient/Guardian Signature	Dr/Hyg. Signature
□	□				
□	□				
□	□				

DENTAL HISTORY

Reason for today's visit _____ Date of last dental care_____
Does dental treatment make you nervous ? _____ Yes _____ No _____ Moderately _____ Extremely
Have you ever been treated for periodontal disease (gum disease, pyorrhea, trench mouth)? _____ Yes _____ No
Have you lost any teeth ? _____ Yes _____ No _____ If yes, have they been replaced with one of the following? :
_____ Fixed Bridges _____ Removable partials _____ Dentures

Check (✓) if you have had problems with any of the following :

- □ Swelling or lumps
- □ Bleeding, sore gums
- □ Bad breath, unpleasant taste
- □ Food impaction
- □ Loose teeth
- □ Shifting of teeth
- □ Change in Bite
- □ Clenching or grinding
- □ Sensitivity to heat
- □ Sensitivity to cold
- □ Sensitive to biting
- □ Sensitive to sweets
- □ Clicking/popping jaw
- □ Difficulty opening or closing jaw

Would you be interested in treatment or information on any of the following dental procedures? Please check (✓)

- □ Bridges
- □ Partials
- □ Dentures
- □ Implants
- □ Porcelain veneers
- □ Cosmetics
- □ Bleaching
- □ Bonding
- □ Changing shape of teeth
- □ Replacing discolored fillings

MEDICAL HISTORY

Name of Physician_____ Telephone Number _____

Do you have or have you had any of the following? Please (✓)

- □ Stroke
- □ Any Heart Problems
- □ Prosthetic Heart Valve
- □ Artificial Joint (hip/knee)
- □ Radiation/Chemotherapy
- □ Growths, Tumors, Cancer
- □ High Blood Pressure
- □ Low Blood Pressure
- □ Circulatory Problems
- □ Excessive bleeding
- □ Sinusitis
- □ Asthma
- □ Anemia
- □ Diabetes
- □ Hepatitis
- □ Tuberculosis
- □ Nervous/Mental Disorders
- □ Drug/Alcohol Abuse
- □ Sexually Transmitted Disease
- □ AIDS, HIV+, or ARC

If you are allergic to, or ever had a reaction to the following, please (✓)

- □ Penicillin
- □ Codeine
- □ Sulfa drugs
- □ Erythromycin
- □ Latex
- □ Local Anesthetic
- □ Barbituates/Sedatives
- □ Aspirin
- □ Others : _____

MEDICATIONS

If you are taking any of the following medications, please (✓) and describe

- □ Antibiotics _____
- □ Thyrod medicine_____
- □ Blood thinners _____
- □ Blood pressure medicine_____
- □ Nitroglycerin_____
- □ Cortisone/steroids _____
- □ Insulin/Diabetic drugs _____
- □ Digitalis/heart medication _____
- □ Tranquilizers _____
- □ Bisphosphonates (osteoporosis medication)

Others _____
Have you been told by your physician you need to Pre-med for dental treatment ? _____ Yes _____ No
Pharmacy name _____ Pharmacy phone # _____

Signature of patient, parent or legal guardian _____ **Date** _____