

Name: _____

Date: _____



Dental History	PLEASE CIRCLE	
	YES	NO
Do you have any specific dental problem?		
Do you have dental exams on a routine basis? Last visit?		
Date of last full mouth x-rays?		
Do you think you have active decay or gum disease?		
Do you like your smile? Why?		
Do you want to keep your remaining teeth?		
Do you smoke or chew tobacco?		
Any sores or growth in your mouth?		
Medical History		
Are you under a physician's care now? Why?		
Have you ever been hospitalized or had major operation?		
Please Discuss:		
Have you ever had a serious injury to your head or neck?		
Are you currently pregnant?		
Are you taking any medications, aspirin, or drugs?		
Please list:		
Are you allergic to any medications? Please check box(es) below.		

Please check YES or NO for the following conditions. If YES, please EXPLAIN							
CONDITIONS	YES	NO	Explain		YES	NO	Explain
Skin Cancer				STI's			
HIV/ AIDS				Epilepsy			
Blood Thinning Meds				Alzheimer			
High Blood Pressure				Mental Health			
Low Blood Pressure				Alcoholism			
Circulation Problems				Hepatitis A			
Leg or Lung Clots				Hepatitis B			
Airway Problems				Hepatitis C			
Asthma				Kidney Disease			
Reaction to Anesthesia				Sickle Cell Disease			
Diabetes			TYPE:	Chemotherapy			
Thyroid Problems				Heart Disease			
Cancer			Type:	Artificial Valves/ Pacemakers/implants			
Blood Transfusions							

Have you ever had any other serious illness not checked above? Please discuss. _____

Do you wish to talk privately about any problem? _____

SIGNATURE: _____

DATE: _____

PATIENT OR RESPONSIBLE PARTY

OFFICE USE ONLY:

Reviewed Doctor: _____

DATE: _____

BP: _____

Pulse: _____

LILIANA C. GONZALEZ DDS, PA & ASSOCIATES



PATIENT INFORMATION

DATE:

NAME:

LAST

FIRST

MARITAL STATUS: MARRIED SINGLE CHILD

GENDER: FEMALE MALE

ADDRESS:

STREET

APT #

CITY

STATE

ZIP

SSN:

BIRTHDATE:

MONTH

DAY

YEAR

EMAIL ADDRESS:

TELEPHONE:

HOME

WORK

CELL

BEST WAY TO CONFIRM APPOINTMENTS :

TEXT

CELL

HOME

EMAIL

NAME OF EMPLOYER:

IF STUDENT, NAME OF SCHOOL:

EMERGENCY CONTACT

NAME:

ADDRESS:

CITY/ STATE/ZIP:

TELEPHONE#:

DENTAL INSURANCE

INSURANCE COMPANY:

PRIMARY INSURED:

SUBSCRIBER DOB:

ID#/SS#:P

GROUP#

HOUSEHOLD FAMILY RELATIONS

NAME: _____

NAME: _____

NAME: _____

NAME: _____

HOW DID YOU HEAR ABOUT OUR OFFICE?

HAS ANY OF YOUR FAMILY EVER BEEN TREATED IN OUR OFFICE?

YES NO

IF YES, NAME OF FAMILY MEMBER

SIGNATURE:

DATE: