Advanced Cosmetic, TMJ Rehabilitation and Family Restorative Dentistry

Gonzalez Dental Care

Patient Information

Patient Name_____ **D.O.B** ___/____/___ Referred By_____
Social Security Number_____-____-_____ Male _____ Female_____
Married __ Single___ Divorced___ Widowed___

Home Address
City_____ State_____ Zip_____
Home Phone_____ Work Phone _____
Cell Phone_____ E-Mail Address_____
Your preferred way for us to reach you during work hours_____

Name of Person Responsible for Account:_____
D.O.B___/____/_____ **SSN**_____
Relationship to Patient_____ Male ____ Female_____
Address_____
City_____ **State**_____ **Zip Code**_____
Home Phone_____ **Work Phone**_____
Employer_____ Occupation_____
Business address_____
City_____ State_____ Zip Code_____

SPOUSE'S Name:_____
D.O.B _____/_____/_____ SSN_____
Employer_____ Occupation_____

Emergency Contact Person:_____ Relationship:_____
Phone Number #1_____ Phone Number #2_____
Address_____
City_____ State_____ Zip Code_____

Primary Insurance Information

Employee:_____
Birth Date:_____ SSN_____
Employer:_____
Ins Co._____
Group #_____ Phone #_____
Address:_____

Secondary Insurance Information

Employee:_____
D.O.B:_____ SSN_____
Employer:_____
Ins Co:_____
Group #_____ Phone #_____
Address:_____

_____ Signature

_____ Date

CONSENT FOR TREATMENT: I hereby grant authority to the dentist(s) in charge of the care of the patient whose name appears on this health history form, to administer such anesthetic, and sedatives; and to perform such operations as may be deemed necessary or advisable in the diagnosis and treatment of this patient. I have been informed of all possible complications of the procedures, anesthetics and/or drugs.

Signature_____ Date_____