Gonzalez Dental Group

We are happy to welcome you to our office! Please completely fill out this form and if you have any questions, we will be glad to help you!

Patient Information

Date _____ Marital Status _____

Patient's last name _____ First name _____ Middle initial _____

Social Security# _____ Date of Birth _____ Sex O Male O Female

Email address _____ School _____

Home address _____ City, State, Zip code _____

Home phone # _____ Cell phone # _____

Emergency contact _____ Phone Number _____

Parent / Guardian (if patient is under 18)

Custodial parent(s) name(s) _____

Patient lives with (check all that apply) O Mother O Father O Stepmother O Stepfather O Grandparent(s)

O Other _____

Primary Guardian Full Name _____ Date of Birth _____

Occupation _____ Email address _____

Address (if different) _____

Home Ph. ( ) _____ Cell Ph. ( ) _____ Work Ph. ( ) _____

Secondary Guardian Full Name _____ Date of Birth _____

Occupation _____ Email address _____

Address (if different) _____

Home Ph. ( ) _____ Cell Ph. ( ) _____ Work Ph. ( ) _____

Dental Insurance

Primary policy holder's full name _____ Date of Birth _____

Social Security # _____ Relationship to patient _____

Address and phone (if not listed above) _____

Employer _____ Address _____

Insurance company _____ Group # _____ ID# _____

Secondary policy holder's full name _____ Date of Birth _____

Social Security # _____ Relationship to patient _____

Address and phone **(if not listed above)** _____

Employer _____ Address _____

Insurance company _____ Group # _____ ID# _____

HOW DID YOU HEAR ABOUT US? Please circle.

- o Family/friends Office sign
- o Insurance plan Newspaper
- o Office transfer Our website
- o Online search/ ad Direct mail

Who may we thank for referring you here? _____

Patient/Guardian Signature _____ ***Date*** _____

Dental Medical History Form

Gonzalez Dental Group

Physician Name: _____ Date of last visit: _____

Although we primarily treat the area in and around the mouth, one's mouth is a part of the entire body. Previous health problems and/or medication could have an important interrelationship with the dentistry the patient will receive. Please answer each of the following questions as completely as possible. Thank you!

Are you under a physician's care now?	O Yes O No	If yes _____
Have you ever been hospitalized or had a major operation?	O Yes O No	If yes _____
Have you ever had a serious head or neck injury?	O Yes O No	If yes _____
Are you taking medications, pills, or drugs? If yes please list them.	O Yes O No	If yes _____
Are you on a special diet?	O Yes O No	If yes _____
Do you Smoke?	O Yes O No	If yes _____
Are you taking or had taken Bisphosphonates? If yes since when?	O Yes O No	If yes _____

Women: Are You...? Pregnant/Trying to get pregnant **O Yes O No** Nursing **O Yes O No** Taking Oral Contraceptives **O Yes O No**

Is the patient allergic to any of the following?

O Aspirin O Penicillin O Codeine O Acrylic
O Metal O Latex O Local Anesthetics
Other Allergy? O Yes O No If yes _____

Do you have or had, any of the following?

ADD/ADHD	O Yes O No	Convulsions	O Yes O No	Hepatitis B or C	O Yes O No	Scarlet Fever	O Yes O No
AIDS/HIV Positive	O Yes O No	Cortisone Medicine	O Yes O No	Herpes	O Yes O No	Shingles	O Yes O No
Anaphylaxis	O Yes O No	Diabetes I	O Yes O No	High Blood Pressure	O Yes O No	Sickle Cell Disease	O Yes O No
Anemia	O Yes O No	DiabetesII	O Yes O No	High Cholesterol	O Yes O No	Sinus Trouble	O Yes O No
Angina	O Yes O No	Drug Addiction	O Yes O No	Hives or Rash	O Yes O No	Stomach/Intestinal Disease	O Yes O No
Anxiety' Disorder	O Yes O No	Easily Winded	O Yes O No	Hypoglycemia	O Yes O No	Stroke	O Yes O No
Arthritis/Gout	O Yes O No	Emphysema	O Yes O No	Irregular Heartbeat	O Yes O No	Swelling of Limbs	O Yes O No
Artificial Heart Valve	O Yes O No	*Epilepsy or Seizures	O Yes O No	Kidney Problems	O Yes O No	Thyroid Disease	O Yes O No
Artificial Joint	O Yes O No	Excessive Bleeding	O Yes O No	Leukemia	O Yes O No	Tonsillitis	O Yes ONo
Asperger's	O Yes O No	Excessive Thirst Fainting	O Yes O No	Liver Disease	O Yes O No	Tuberculosis	O Yes O No
Asthma	O Yes O No	Frequent Cough	O Yes O No	Low Blood Pressure	O Yes O No	Tumors or Growths	O Yes O No
Autism	O Yes O No	Frequent Diarrhea	O Yes O No	Lung Disease	O Yes O No	Ulcers	O Yes O No
Blood Disease	O Yes O No	Frequent Headaches	O Yes O No	Mitral Valve Prolapse	O Yes O No	Venereal Disease	O Yes O No
Blood Transfusion	O Yes O No	Glaucoma	O Yes O No	Pain in Jaw Joints	O Yes O No	Yellow Jaundice	O Yes O No
Breathing Problems	O Yes O No	Hay Fever	O Yes O No	Parathyroid Disease	O Yes O No	Osteoporosis	O Yes O No
Bruise Easily	O Yes O No	Heart Attack/Failure	O Yes O No	Psychiatric Care	O Yes O No		
Cancer	O Yes O No	Heart Murmur	O Yes O No	Radiation Treatments	O Yes O No		
Chemotherapy	O Yes O No	Heart Pacemaker Heart	O Yes O No	Recent Weight Loss	O Yes O No		
Chest Pains	O Yes O No	Trouble/Disease	O Yes O No	Renal Dialysis	O Yes O No		
Cold Sores/Fever Blisters	O Yes O No	Hemophilia	O Yes O No	Rheumatic Fever	O Yes O No		
Congenital Heart Disorder	O Yes O No	Hepatitis A	O Yes O No	Rheumatism	O Yes O No		

*__When was your last dental appointment?__ _____

__Why did you leave your last dentist?__ _____

__Reason for today's visit?__ _____

__Have you ever had periodontal treatment? If yes, when?__ _____

Do you have any of the following conditions and habits?

O Bad Breath O Suck/BiteLip O Chew/Bite nails O Sensitive teeth?
O Chew hard objects O Grind Teeth O Clench Jaw Hot/cold/sweet

How often fo you floss? _____
How often do you brush? _____

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to the patients' health. It is my responsibility to inform the dental office of any changes in the patients' medical status. I also authorize the dental staff to perform the necessary dental services the patient may need.

X_____ _____
Signature of Patient, Parent or Guardian Date

This form has been reviewed with Patient, Parent or Guardian and conditions accurately notated.

X_____ _____
Signature of Providing Dentist Date

Gonzalez Dental Group

DENTAL TREATMENT CONSENT FORM

Please read and initial the items checked below
and read and sign the section at the bottom of form. Patient Name_____

1. **WORK TO BE DONE**
Exam and x-rays. (Initials_____)

2. **DRUGS AND MEDICATIONS**
I understand that antibiotics and analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain itching vomiting, and/or anaphylactic shock (severe allergic reaction). (Initials_____)

3. **CHANGES IN TREATMENT PLAN**
I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the Dentist to make any/all changes and additions, as necessary. (Initials_____)

4. **REMOVAL OF TEETH**
Alternative to removal have been explained to me (root canal therapy, crowns, and periodontal surgery, etc.) and I authorize the Dentist to remove the following teeth_____and any others necessary for reasons in paragraph #3. I understand removing teeth does not always remove all the infection. if present, and it may be necessary to have further treatment. I understand the risks involved is having teeth removed, some of which are pain, swelling, spread of infection, dry socket, loss of feeling in teeth, lips, tongue, and surrounding tissue (Paresthesia) that can last for an indefinite period (day or months) or fractured jaw. I understand I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment, the cost for which is my responsibility. (Initials_____)

5. **CROWN, BRIDGES AND CAPS**
I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realize the final opportunity to make changes in my new crown, bridge, or cap (including shape, fit, size, and color: will be before cementation. (Initials_____)

6. **DENTURES, COMPLETE OR PARTIAL**
I realize that full or partial dentures are artificial, constructed of plastic, metal, and/or porcelain. The problems of wearing these appliances have been explained to me, including looseness, soreness, and possible breakage. I realize that the final opportunity to make changes in my new dentures (including shape, fit, size, placement, and color) will be the "teeth in wax" try-in last visit. I understand that most dentures require relining approximately three to twelve months after initial placement. The cost for this procedure is not included in the initial denture fee. (Initials_____)

7. **ENDODONTIC TREATMENT (ROOT CANAL)**
I realize there is no guarantee that root canal will save my tooth, and that complications may occur from the treatment, and occasionally metal objects are cemented in the tooth or extend through the root, which does not necessarily affect the success of the treatment. I understand that occasionally additional surgical procedures may be necessary following root canal treatment. (Apicoectomy). (Initials_____)

8. **PERIODONTAL LOS (TISSUE & BONE)**
I understand that I have serious condition, causing gum and bone infection or loss and that it can lead to the loss of my teeth. Alternative treatment plans have been explained tome, including gum surgery, replacements and/or extractions. I understand that undertaking any dental procedures may have a future adverse effect on my periodontal condition. (Initials_____)

9. **FILLINGS**
I understand that care must be exercise in chewing on filling especially during the first 24 hours to avoid breakage. You understand that a more extensive filling than originally diagnose may be required due to additional decay. I understand that significant sensitivity is common after effect of a newly placed filling. (Initials_____)

10. OTHER (Initials_____)

I understand that dentistry is not an exact science and that, therefore, reputable practioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorized. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction. I consent to the proposed treatment.

Patient Signature_____Date_____

Doctor Signature_____Date_____

Gonzalez Dental Group

Financial Policy

Welcome to our office and thank you for choosing us to serve your dental needs. We would like to take this opportunity to notify you of our policies as they relate to health care cost that may be incurred while you visit our office. Hopefully, this will make your visit pleasant and assist you in meeting any financial obligation in a timely fashion.

As a courtesy to our patients, we do bill your insurance carrier. **Please be aware that the filling of insurance claims does not guarantee payment by your insurance carrier.** Frequently proof of eligibility, covered and non covered services and various exclusions cannot be determined until your carrier processes the claim. Therefore, we do submit insurance claims with the understanding that you are responsible for any non0covered services, co-payments, deductibles and exclusions, cosmetic services at the time of service is rendered. I understand that insurance estimate are estimates only and not a guaranteed of benefits and based on my eligibility. I also understand and accept responsibility for any insurance claims not paid within 45 days of the billing service.

Our office will do our best to verify eligibility however; it is in your best interest to be aware of your eligibility status. It is also patient's responsibility to inform us of any changes and or dual coverage. I am aware that unless other specific arrangements are made beforehand, payment is due at the time of treatment. We accept cash, Visa, Master Card, Amex, Discover and Care Credit (financing company)

There is a $25 charge for returned checks.

We understand that there are emergency situations that can interfere with even the best of plans, However we do require a 48 hour advance notice to cancel or change an appointment, as many dental procedures may take anywhere from one to three hours. Our office reserves time specifically for you and the doctor/hygienist. We do have the right to charge for broken appointments by the hour.

I have reviewed the above policy and understand that I responsible for the entire balance of my treatment and for complying with the terms of my payment option I have chosen. I further understand that any balance over 45 days past due will be subject to a 1.5% per month (18% per annum) finance charge and that will be liable for any fees incurred in collecting any delinquent balance.

I hereby acknowledge that I have read, understand and agree to abide by the terms set forth in this document.

Patient/Responsible Party: _____Date_____

Gonzalez Dental Group

Notice of Privacy Practices Update 9/2013

This notice describes how your health information may be used and disclosed, and how you can access this information. Please review it carefully.

At **Gonzalez Dental Group**, we are required to keep your health information secure and confidential, by law. Also by law, we need to give you this notice and to follow the terms of this notice. The law permits us to use or disclose your health information to those involved in your treatment. For example, a review of your file by a specialist doctor whom we may involve in your care. We may use or disclose your health information for payment of your services. For example, we may send a report of your treatment or progress to your insurance company. We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your treatment information into our computer system. We may share your medical information with our business associates, such as a billing service. We have a written contract with each business associate that requires them to protect your privacy. We may use your information to contact you. For example, we may send newsletters or other information to you. We may also call and remind you about your appointments. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone. In an emergency, we may disclose your health information to a family member or another person responsible for your care. We will need to release some or all of your health information, when required by law. If this practice is sold, your information will become the property of the new owner.

Except as described above, this practice will not use or disclose your health information without your prior written authorization. You may request in writing that we not use or disclose some or all of your health information as described above. We will let you know if we can fulfill your request.

You have the right to know of any uses or disclosures we make with your health information beyond the above normal uses. You have the right to receive communication about your health information in the manner you prefer. We will also use whatever communication method, number or system you prefer to contact you. You have the right to transfer a copy of your health information to another practice. Notify us in writing of where you would like us to send a copy of your health information for you. You have the right to see and receive a copy of your health information, with a few exceptions. Give us a written request regarding the information you want to see. If you want a copy of your records, we may charge you a reasonable fee for the copies. If you would like a digital copy of your records, let us know which type of file you would like and we will try to meet your needs. You have the right to request an amendment or change to your health information, in writing. If you wish to include a statement in your file, please give it to us in writing. We may or may not make the changes you request, but will include your statement in your file. If we agree to an amendment or change, we will not remove nor alter earlier documents, but will add new information. You have the right to receive a report of who we disclose your information to. If our privacy and security measures or systems are breached in any way, we will notify you. You have the right to receive a copy of this notice. If we change any of the details of this notice, we will notify you of the changes in writing. You may file a complaint with the **Department of Health and Human Services in writing (200 Independence Avenue, S.W., Room 509F, Washington, DC 20201), online (http://www.hhs.gov) or by email (OCRComplaint@hhs.gov). You will not be retaliated against for filing a complaint.**

Purpose of consent: by signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations. Notice of Privacy Practices: you have the right to read our notice of Privacy Practices before you decide whether to sign this consent. This notice provides a description of our treatment payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and other important matters about your protected health information. A copy of our Notice of Practices is available to you. We reserve the right to change our Privacy practices as described in our Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice at any time, as well for more information, to make a request, to file a complaint with us or for assistance regarding your health information privacy at:
Gonzalez Dental Group 2139 Tapo St #101 Simi Valley Ca. 93063 805.582.2571

I_____(patient's name) have had full opportunity to consider the contents of this consent form and your Notice of Privacy Practices. I understand that, by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment and we may also decline to treat you or to continue treating you if you revoke this consent.

Acknowledgment

Signed _____ Print Name _____Date_____

If signing as a parent or guardian, please note the name of the patient _____

BACK TO PRACTICE

PATIENT CARE

Gonzalez Dental Group

Covid-19 Patient Screening Form

Temp:_____

Instructions for use: Use one form for each patient appointment. Ask the patient these questions at the time appointment is made or with appointment reminder, and again no more than two days before the appointment.

Patient/Parent/Guardian Names: _____ **Date:** _____

Screening questions			
Are you fully vaccinated for COVID-19? *An individual is considered fully vaccinated if it has been more than 2 weeks since they received the last shot of a 2-dose vaccine (for example, Moderna or Pfizer) or a single dose vaccine (J&J).*	☐ No ☐ Yes	**Do you have a fever or above normal temperature (>100.0° F)? *Take temperature at appointment.*** *If patient answers "yes," note the symptoms reported and seek additional information from the patient about possible cause. If patient does not need emergency care, consider not scheduling or seeing the patient until symptoms resolve.*	☐ No ☐ Yes
Are you experiencing more than one of the following symptoms: shortness of breath, dry cough, sore throat, unexplained muscle pain, headache or nausea, new loss of taste or smell? *If patient answers "yes," note the symptoms reported and seek additional information from the patient about possible cause.If patient does not need emergency care, consider not scheduling or seeing the patient until symptoms resolve.*	☐ No ☐ Yes	**Even if you don't currently have any of the above symptoms, have you experienced more than one of these symptoms in the last 14 days?** *If "yes" and patient does not need emergency care, do not see patient unless it has been more than 10 days since symptoms first appeared and 24 hours of no fever without use of fever-reducing medication.*	☐ No ☐ Yes
Have you been advised to quarantine due to close contact with someone diagnosed with COVID-19? *If yes, ask when the quarantine period ends and set appointment time after that date.*	☐ No ☐ Yes	**Have you been tested for COVID-19 in the last 14 days? *If "no," proceed to next question.*** ***If yes,** what is the result of the testing?* ***If negative,** proceed to next question.* ***If still waiting on results,** schedule appointment after results are known.*	☐ No ☐ Yes ☐ Unsure ☐ Positive
Have you traveled out of state or out of country in the last 14 days? *Fully vaccinated individuals need not quarantine, according to the CDC. Know your county's health officer orders with regard to non-essential travel by individuals not vaccinated for COVID-19. The county orders will have quarantine recommendations.*	☐ No ☐ Yes		

Patient signature required at appointment:

I agree to notify the dental practice if within 2 days I become ill with COVID-19 symptoms or test positive for COVID-19. I understand the dental practice has a legal and ethical obligation to inform me if a staff person I had close contact with tested positive for COVID-19 within 2 days.

Signature _____