



Gentle Family & Implant Dentistry of Laredo

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www.GentleLaredoDentist.com

Date _____ Home Phone _____

PATIENT INFORMATION

Name _____ Soc. Sec. # - -
Last Name First Name Initial
 Email Address _____ Cell Phone _____
 Address _____
 City _____ State _____ Zip _____
 Sex M F Age _____ Birthdate _____ Single Married Widowed Seperated Divorced
 Patient Employed by _____ Occupation _____
 Business Address _____ Business Phone _____
 Whom may we thank for referring you? _____
 In case of emergency who should be notified? _____ Phone _____

PRIMARY INSURANCE

Person Responsible for Account _____
Last Name First Name Initial
 Relation to Patient _____ Birthdate _____ Soc. Sec. # - -
 Address (if different from patients) _____ Phone _____
 City _____ State _____ Zip _____
 Person Responsible Employed by _____ Occupation _____
 Business Address _____ Business Phone _____
 Insurance Company _____
 Contact # _____ Group# _____ Subscriber # _____
 Names of other dependents covered under this plan _____ Phone _____

ADDITIONAL INSURANCE

Is patient covered by additional insurance? Yes No
 Subscriber Name _____ Relation to Patient _____ Birthdate _____
 Address (If different from patient's) _____ Phone _____
 City _____ State _____ Zip _____
 Subsciber Employed by _____ Business Phone _____
 Insurance Company _____ Soc. Sec. # - -
 Contact # _____ Group # _____ Subscriber # _____
 Names of other dependents covered under this plan _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____
Name of Insurance Compan(ies)
 and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to
 me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby
 authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all
 insurance submissions.

Responsible Party Signature

Relationship

Date

DENTAL HEALTH HISTORY (Confidential)

DENTAL HISTORY

Reason for Today's Visit _____

Former Dentist _____

Address _____

Date of last dental care _____ Date of last dental X-rays _____

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

- | | | |
|--|---|---|
| <input type="checkbox"/> Bad breath | <input type="checkbox"/> Grinding teeth | <input type="checkbox"/> Sensitivity to hot |
| <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Loose teeth or broken fillings | <input type="checkbox"/> Sensitivity to sweats |
| <input type="checkbox"/> Clicking or popping jaw | <input type="checkbox"/> Periodontal treatment | <input type="checkbox"/> Sensitivity when biting |
| <input type="checkbox"/> Food collection between teeth | <input type="checkbox"/> Sensitivity to cold | <input type="checkbox"/> Sores or growths in your mouth |

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

MEDICAL HISTORY

Physician's Name _____ Date of Last Visit _____

Have you had any serious illnesses or operations? _____ If yes, describe _____

Have you ever had a blood transfusion? Yes No If yes, give approximate dates _____

(Women) Are you pregnant? Yes No Nursing? Yes No Taking Birth Control Pills? Yes No

Are you taking any type of blood thinners? Yes No Do you take, or have you taken, Phen-Fen or Redux? Yes No

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Yes No

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

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Cortisone Treatments | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Cough, Persistent | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Arthritis, Rheumatism | <input type="checkbox"/> Cough up Blood | <input type="checkbox"/> HIV Positive | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Jaw Pain | <input type="checkbox"/> Skin Rash |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fainting | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Swelling of Feet or Ankles |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Headaches | <input type="checkbox"/> Nervous Problems | <input type="checkbox"/> Tobacco Habit |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Heart Pacemakers | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Respiratory Disease | <input type="checkbox"/> Venereal Disease |

MEDICATIONS

List medications you are currently taking:

Pharmacy Name _____

Phone _____

ALLERGIES

- | | |
|--|--------------------------------------|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Penicillin |
| <input type="checkbox"/> Barbiturates (Sleeping Pills) | <input type="checkbox"/> Sulfa |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Local Anesthetic | <input type="checkbox"/> _____ |

SIGNATURE

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Date _____ Signature _____