Welcome!

Alma L. Garza, D.D.S.

4118 McCullough, Suite 6 San Antonio, TX 78212

(210) 826-8492

PATIENT INFORMATION

Patient Name: _____ Date:_____
Last First MI

E-mail:_____ ☐ Male ☐ Female **Status**: ☐ Married ☐ Single ☐ Child/Student ☐ Other

Social Security #: _____**Birth Date**: _____ **Driver's License**: _____

Phone (Home): _____ (Work): _____ **Cell** Phone: _____ Text: YES / NO

Address: _____
Street **Apartment #**

_____
City **State** **Zip Code**

Employer Name: _____ Occupation/School: _____

HEALTH INFORMATION

Date of Last Dental Visit: _____ **Reason for this visit**:_____

Have you ever had any of the following? Please write dates on those that apply:

☐ AIDS
☐ Allergies _____
_____
☐ Anemia
☐ Arthritis
☐ Artificial Joints
☐ Asthma
☐ Blood Disease
☐ Cancer
☐ Diabetes
☐ Dizziness
☐ Epilepsy
☐ Excessive Bleeding
☐ Fainting
☐ Glaucoma
☐ Growths
☐ Hay Fever
☐ Head Injuries
☐ Heart Disease
☐ Heart Murmur
☐ Hepatitis
☐ High Blood Pressure
☐ Jaundice
☐ Kidney Disease
☐ Liver Disease
☐ Mental Disorders
☐ Nervous Disorders
☐ Pacemaker
☐ Radiation Treatment
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Rheumatism
☐ Sinus Problems
☐ Stomach Problems
☐ Stroke
☐ Tuberculosis
☐ Tumors
☐ Ulcers
☐ Venereal Disease
☐ Codeine Allergy
☐ Penicillin Allergy
☐ **Latex Allergy**

LIST OF MEDICATIONS
_____
_____
_____

Females: Are you Pregnant or is there A chance you could be?
☐ YES ☐NO
Due Date:_____

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain:_____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain:_____
- Are you now under the care of a physician? ☐ Yes ☐ No Name of Medical Doctor:_____
  If yes, please explain:_____ Phone # of Medical Doctor:_____
- Do you require Prophylactic Antibiotic Premedication? ☐ Yes ☐ No

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ Date: _____
Signature of patient, parent or guardian

_____ Date: _____
Signature of Dentist

REFERRAL INFORMATION

Whom may we thank for referring you to our practice? ☐Another patient, friend ☐another patient, relative

Name of person or office referring you to our practice:_____

PHARMACY INFORMATION

Name of Pharmacy: _____ Phone#:_____ Location: _____

RESPONSIBLE PARTY INFORMATION --- OTHER THAN PATIENT

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone/Cell: _____ (Work): _____ Text: YES/NO e-mail address: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Employer Name: _____ Occupation: _____

INSURANCE INFORMATION (if no insurance, leave blank)

Primary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #:_____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

Insurance Plan Name and Address: _____

_____

* SECONDARY INSURANCE ☐ Yes ☐ No If Yes, please provide information

Assignment of Benefits

I certify that I, and/or my dependent(s), parents, or guardian have insurance coverage with _____and assign directly to **Alma L. Garza, D.D.S.** all insurance benefits, if any, otherwise payable to me for rendered services. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above named dentist may use my health care information and may disclose such information to the above named insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

_____ Date: _____ Relationship to Patient: _____

Signature of patient, parent or guardian

Consent for Diagnosis and Treatment

I, _____, hereby authorize and request the treatment and diagnosis of dental services for myself or the above named. I also give my consent to any advisable and necessary radiographs, dental procedures, medications, or anesthetics to be administered by Dr. Alma L. Garza or by the supervised staff for diagnostic purposes or dental treatment. I understand and acknowledge that I am financially responsible for the services provided for myself or the above named regardless of insurance purposes.

_____ Date:_____ Relationship to Patient:_____

Signature of patient, parent or guardian

Acknowledgement of Receipt of Notice of Privacy Practices

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____ Date:_____ Relationship to Patient:_____

Signature of patient, parent or guardian