# Patient History Update

Dr. Andrea D. Gordillo D.M.D., PA & Associates

***Patient Information (Confidential):***

Name _____ (If child, parent/guardian name) _____
*Last name* *First name* *Last name* *First name*

Birthdate _____ Sex _____ Age _____ Soc Sec # _____Marital Status_____
Home Address _____ City _____ State _____ Zip _____
Home Phone _____ Work Phone _____ Cell Phone _____
Email _____ Would you like us to confirm your appointment with email? _____

***Primary Insurance (Dental):***

Name of Insured: _____
Birthdate: _____ Relationship to patient _____
Address (if different than patient) _____
Insurance Company: _____
Social Security # _____ Subscriber ID _____
Group, Contract , Local or Union # _____
Employer: _____

***Additional Insurance (Dental):***

Name of Insured: _____
Birthdate: _____ Relationship to patient _____
Address (if different than patient) _____
Insurance Company: _____
Social Security # _____ Subscriber ID _____
Group, Contract , Local or Union # _____
Employer: _____

***Authorization:***

I understand that I am responsible for all charges whether or not they are covered by insurance, as well as any additional collections costs if this office determines they are necessary. Our office can only ***estimate*** insurance benefits, and therefore can not guarantee your portion. I authorize my insurance company to make payments directly to Dr. Gordillo & Associates for benefits otherwise payable to me. I authorize release of my records to third party payers, other healthcare professionals or operations, or other entities deemed necessary by this office. I authorize use of this signature for all insurance submissions.

I have read and understand the above and agree to comply. **X** _____ _____
Patient Signature Date

***Medical History (Confidential):***

Physicians Name: _____
City _____ Phone _____
Have you been hospitalized for any reason? _____
Please Describe: _____
_____
Are you seeing a physician now or planning to see one for any reason? Please explain: _____
_____
_____
_____

Are you allergic to penicillin, aspirin, local anesthetics, latex, sulfa, codeine, other? _____
Do you smoke? How much/day? _____
Pregnant? Due Date _____ Are you nursing? _____
Are you taking any medications or drugs (including nutritional supplements?) Please list: (Continue on back of form if needed)
_____
_____
_____
_____

*Write YES for all that apply:*

| | | | |
|---|---|---|---|
| Latex Allergy _____ | Irregular Heartbeat _____ | Bleeding Problems _____ | Cancer _____ |
| Joint Replacement _____ | Atrial Defibriation _____ | Asthma _____ | HIV or AIDS _____ |
| High/Low Blood Pressure _____ | Pacemaker _____ | Lung Disease _____ | Acid Reflux _____ |
| Heart Attack _____ | Artificial Heart Valve _____ | Liver Disease _____ | Epilepsy _____ |
| Angina _____ | Congenital Heart Disease _____ | Hepatitis _____ | T.B. _____ |
| Heart Murmur _____ | Blood Disorder _____ | Kidney Disease _____ | Use Tobacco _____ |
| Mitral Valve Prolapse _____ | Stroke _____ | Digestive Disorders _____ | Nickel Allergy _____ |
| Diabetes _____ | Snoring/Sleep Apnea _____ | Atrial Defib. Drugs _____ | Blood Thinners _____ |
| Glaucoma _____ | Fainting or Dizzy _____ | Osteoporosis Drugs _____ | Chemotherapy _____ |
| Drug/Alcohol Addiction _____ | Depression _____ | Birth Control Medications _____ | Radiation Treatment _____ |

Any other illnesses not listed above: _____
_____
_____

I will inform this office of any changes in my health status. I understand that dental treatment and local anesthesia entail risks such as bleeding infection, nerve damage or fracture of teeth or bone. I certify that the above information is complete and accurate to the best of my knowledge.

_____ _____
Patient Signature Date

_____ _____
Dentist Signature Date