Omar Guerra, DDS

1305 Wonder World Dr. Suite 303
San Marcos, TX 78666 (512) 396-3727

Patient Information

Name_____ Home # _____Cell#_____
Address _____City_____State ____ Zip _____
S.S. # _____
Sex _M _F Age ____Date of Birth _____ Marital Status – Married Single Widowed Divorced Separated
Patient Employed By_____ _Occupation_____Phone#_____
Whom may we thank for referring you? _____
In case of EMERGENCY who should we notify_____Phone#_____

PRIMARY INSURANCE

Person Responsible for Account _____
Last Name First Name Initial
Relation to Patient _____DOB _____S.S. # _____
Address (if different from patient's) _____ Phone # _____
City _____ State _____Zip _____
Employed by _____ Occupation _____
Insurance Company _____Phone Number_____
Group # _____Subscriber # _____
Names of other dependents covered under this plan
_____
I, the undersigned certify that I (or my dependent) assign directly to **Dr. Omar Guerra** all insurance benefits, for services rendered. Signature_____

ADDITIONAL INSURANCE

Is patient covered by additional insurance? _____Yes _____No

ASSIGNMENT, PAYMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____
_____and assign directly to **Dr. Omar Guerra** all insurance benefits, 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. Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges, and any other expenses incurred in collecting your account. I understand the above information and have completed this form truthfully and correctly and it will be my responsibility to inform this office of any changes to the information I have provided. I authorize the staff to perform any necessary services needed during diagnosis and treatment.

_____ _____

Dental Info

Reason for today's visit: ☐ Exam ☐ Emergency ☐ Consultation

Are you in pain? ☐ No ☐ Yes How long? _____

Please indicate √ any of the following problems:

☐ Discomfort, clicking or popping in jaw. ☐ Lost/Broken Filling(s) ☐ Stained teeth

☐ Red, swollen or bleeding gums. ☐ Teeth grinding ☐ Locking Jaw

☐ Sensitive tooth, teeth or gums. ☐ Ringing in Ears ☐ Bad breath

☐ Blisters/ Sores in or around the mouth. ☐ Broken/ Chipped tooth

☐Other: _____

Do you require pre-medication? ☐ Yes ☐ No ☐ Don't know

Previous Dentist: _____ (___)_____

Name Phone #

Last Dental exam: ____/____/____ Last Dental X-rays: ____/____/____

Times a day you brush? _____ Times a day you floss? _____

What type of toothbrush bristles do you use? ☐ Soft ☐ Medium ☐ Hard

Medical History

What medications are you taking? ☐ Nerve pills ☐ Pain killers (including aspirin) ☐ Muscle relaxers ☐ Stimulants ☐ Blood thinners ☐ Tranquilizers ☐ Insulin ☐ Meds for Osteoporosis

☐ Other(s), please list: _____

Have you ever taken: Bisphosphonates (ex. Aredia/ Fosamax) ☐ Yes ☐ No Phen-fen/Redux ☐ Yes ☐ No

Do you have or have you had any of the following diseases, medical conditions or procedures?

Y N Heart Attack/ Stroke	Y N Thyroid Problems	Y N Cancer/ Tumors	Y N Cosmetic Surgery
Y N Heart Surg./Pacemaker	Y N Kidney Problems	Y N Shingles	Y N Xray or Cobalt Treatment
Y N Heart Murmur	Y N Liver Problems	Y N Hepatitis	Y N Chemotherapy
Y N Rheumatic Fever	Y N Respiratory Problems	Y N HIV+/AIDS/ARC	Y N Asthma
Y N Mitral Valve Prolapse	Y N Sinus Problems	Y N Arthritis/Rheumatism	Y N Difficulty Breathing
Y N Artificial Valves	Y N Stomach Problems/ Ulcers	Y N Artificial Bones/Joints	Y N Diabetes/ Hypoglycemia
Y N Heart Disease	Y N Psychiatric Problems	Y N Emphysema	Y N Leukemia
Y N Congenital Heart Defect	Y N Venereal Disease	Y N Fainting/Seizures/Epilepsy	Y N Anemia
Y N Chest Pains	Y N Alcohol/ Drug Abuse	Y N Severe/Frequent Headaches	Y N High/ Low Blood Pressure
Y N Scarlet Fever	Y N Tuberculosis TB	Y N Frequent Neck Pain	Y N Bleeding Problems
Y N Nervousness	Y N Jaw Problems TMJ/ TMD	Y N Back Problems	Y N Glaucoma

Please list any other surgeries or medical conditions you have or ever had _____

Are you allergic to any of the following? ☐ Latex ☐ Penicillin/Amoxicillin ☐ Tetracycline ☐Asprin

☐ Dental Anesthetics ☐ Foods: _____ ☐ Others: _____

Do you use tobacco? ☐ No ☐ Yes/ How used?_____ How much/long? _____

For women: Are you taking Birth Control pills? ☐ Yes ☐ No How many children have you had? _____

Are you pregnant? ☐ No ☐ Yes/How long? _____ Are you nursing? ☐ Yes ☐ No

ACKNOWLEDGMENT OF RECIEPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received the Notice of Privacy Practices.

Information to be disclosed may consist of complete health and financial record(s) to a referring dentist, insurance company for process of payment, or a third party that has been chosen by me.

_____ _____

Signature of patient or legal representative Date

Printed Name of Patient(s) Relationship

_____ _____

_____ _____

_____ _____

ELECTRONIC HEALTH INFORMATION

This is to certify that I understand this office often uses an electronic form of communication (recall reminders, appointment confirmations, news letters, etc) via email/text.

I Do allow this office to contact me electronically,

_____ _____

Email address Cell Phone

_____

Print Name Signature Date