

**Patient Information**

Date: \_\_\_\_\_ Time: \_\_\_\_\_

Patient is:  Policy Holder  Responsible Party

Patient Name: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

E-Mail: \_\_\_\_\_

Yes, I would like to receive appointment reminders and correspondences via email from Sun City Dental.

Address: \_\_\_\_\_  
 City: \_\_\_\_\_  
 State/Zip code: \_\_\_\_\_  
 Cell Phone: \_\_\_\_\_

Yes, I would like to receive appointment reminders via Text Messages from Sun City Dental.

Home Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Ext# \_\_\_\_\_

Sex:  Male  Female

Marital Status:  Married  Widowed  Single  Minor  
 Divorced  Separated  Partnered for \_\_\_\_\_ years

Birth date: \_\_\_\_\_ Age: \_\_\_\_\_

Soc. Sec: \_\_\_\_\_

Driver License: \_\_\_\_\_

Employment Status:  Full Time  Part Time  Retired

Student Status:  Full Time  Part Time

Patient Employer/School \_\_\_\_\_

Employer/School Address: \_\_\_\_\_  
 \_\_\_\_\_

Employer/School Phone: \_\_\_\_\_

**Emergency Contacts:**

Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_

**Who may we thank for referrine: you?**

Referred by: \_\_\_\_\_

**Dental Insurance**

Who is responsible for this account?  
 Name of Insured: \_\_\_\_\_

Relationship to Patient:  Self  Spouse  Child  Other

Insured Soc Sec: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Ins. Company: \_\_\_\_\_

Group/Member ID #: \_\_\_\_\_

Ins. Company Address \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Insured Employer: \_\_\_\_\_

Address: \_\_\_\_\_  
 \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Is patient covered by additional insurance? Yes  No

Name of Insured: \_\_\_\_\_

Relationship to Patient:  Self  Spouse  Child  Other

Insured Soc Sec: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Ins. Company: \_\_\_\_\_

Group/Member ID #: \_\_\_\_\_

Insured Employer: \_\_\_\_\_

Address: \_\_\_\_\_  
 \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

**ASSIGNMENT AND RELEASE**

I certify that I, and/or my dependent(s) have insurance coverage with

\_\_\_\_\_  
 Name of Insurance Company(ies)

and assign directly to Dr. Iven Gonzalez 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 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(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Signature of Patient, Parent, Guardian Or Personal Representative

Please Print name of Patient, Parent, Guardian or Personal Representative \_\_\_\_\_

Date \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

**Dental History**

Reason for today's visit _____	Chew on one side of mouth	Yes <input type="radio"/> No <input type="radio"/>	Mouth pain. brushing	Yes <input type="radio"/> No <input type="radio"/>
Former Dentist _____	Cigarette, pipe, or cigar smoking	Yes <input type="radio"/> No <input type="radio"/>	Orthodontic treatment	Yes <input type="radio"/> No <input type="radio"/>
City/State _____	Clicking or popping jaw	Yes <input type="radio"/> No <input type="radio"/>	Pain a round ear	Yes <input type="radio"/> No <input type="radio"/>
Date of last dental visit _____	Dry mouth	Yes <input type="radio"/> No <input type="radio"/>	Periodontal treatment	Yes <input type="radio"/> No <input type="radio"/>
Data or last dental X- rays _____	Fingernail biting	Yes <input type="radio"/> No <input type="radio"/>	Sensitivity to cold	Yes <input type="radio"/> No <input type="radio"/>
Place a mark on "yes" or "no" to Indicate if you have had any of the following:	Food collection between the teeth	Yes <input type="radio"/> No <input type="radio"/>	Sensitivity to heat	Yes <input type="radio"/> No <input type="radio"/>
Bad breath	Foreign objects	Yes <input type="radio"/> No <input type="radio"/>	Sensitivity to sweets	Yes <input type="radio"/> No <input type="radio"/>
Bleeding gums	Grinding teeth	Yes <input type="radio"/> No <input type="radio"/>	Sensitivity when biting	Yes <input type="radio"/> No <input type="radio"/>
Blisters on lips or mouth	Gums swollen or tender	Yes <input type="radio"/> No <input type="radio"/>	Sores or growths in your mouth	Yes <input type="radio"/> No <input type="radio"/>
Burning sensation on tongue	Jaw pain or tiredness	Yes <input type="radio"/> No <input type="radio"/>	How often do you floss? _____	
	Lip or cheek biting	Yes <input type="radio"/> No <input type="radio"/>	How often do you brush? _____	
	Loose teeth or broken fillings	Yes <input type="radio"/> No <input type="radio"/>		
	Mouth breathing	Yes <input type="radio"/> No <input type="radio"/>		

Signature:

Sun City Dental
Eaglesoft Medical History

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

- Are you under a physician's care now? Yes No If yes
Have you ever been hospitalized or had a major operation? Yes No If yes
Have you ever had a serious head or neck injury? Yes No If yes
Are you taking any medications, pills, or drugs? Yes No If yes
Do you take, or have you taken, Phen-Fen or Redux? Yes No If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Yes No If yes
Are you on a special diet? Yes No
Do you use tobacco? Yes No

Women: Are you... Pregnant/Trying to get pregnant? Nursing? Taking oral contraceptives?

Are you allergic to any of the following?

- Aspirin Penicillin Codeine Acrylic Metal Latex Sulfa Drugs Local Anesthetics
Other? If yes

Do you use controlled substances? Yes No If yes

Do you have, or have you had, any of the following?

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

Have you ever had any serious illness not listed Yes No If yes

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 my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, or Guardian:

Date:

**Sun City Dental, PLLC**  
11240 Montwood Dr. Suite J El Paso, TX 79936  
Ph: (915) 201-2539 Fax: (915) 613-5082

### Office Policies

Thank you for reviewing the following office policies. We commit to putting forward our best efforts to provide you with the most up to date, skilled, and compassionate dental care possible. In return we respectfully ask you to agree to the following:

#### Missed Appointment Policy - Please Initial

- Dr. Gonzalez reserves your appointment time exclusively for you. If you need to reschedule your appointment, we kindly ask you to please call our office 48 hours prior to your scheduled appointment so that another patient may have your appointment time. A fee of \$50 fee will be charged to your account for rescheduling, cancelling, or failing to show up for your appointment without a prior 48 business hours notice.
- If you are more than 15 minutes late, you may be asked to reschedule. A \$30.00 fee may also be charged to your account upon 2 consecutive appointments where you come in late 15 minutes or more.

#### Office Fees Policy - Please Initial

- Payment for services is due at the time of office visit. Payment options include Cash, MasterCard, Visa, American Express, Discover, and Care Credit.
- As a courtesy to our patients, we file all claims to the insurance company. The patient is expected to pay all charges not covered by the insurance at the date of service. If the insurance does not pay a claim, the patient will be responsible for charges and will be billed.
- Any balance remaining after your insurance has paid will be due within 30 days. If payment is not received your account may be referred to a collections agency.
- Your dental insurance benefits are verified by our office according to information provided by you. The benefits quoted by your insurance company are just an estimate and are NOT A GUARANTEE OF COVERAGE. You will be responsible for any amount not covered.
- Please be aware that some insurance companies downgrade the price of composite fillings to the amalgam price. Our office compensates for this by adjusting the percentages for restorative work. It is your responsibility to confirm with your insurance if we are in or out of your network, and if the service you request is covered by your insurance.
- All co-pays, co-insurance, and deductibles must be paid at the time of service. Any accounts with outstanding balances must be paid prior to any additional services being rendered.
- A \$40.00 charge will be added to your account for any returned checks.

**We look forward to having you as our patient!**

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I HAVE READ AND ACCEPT THE OFFICE POLICIES. I ALSO UNDERSTAND THAT I AM ULTIMATELY RESPONSIBLE FOR ALL CHARGES INCURRED FOR DENTISTRY PERFORMED UPON MYSELF IN THIS DENTAL PRACTICE.

Print Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# Acknowledgement of Receipt of HIPAA Notice of Privacy Practices

*\*You May Refuse to Sign This Acknowledgement\**

**I have received a copy of Sun City Dental, PLLC Notice of Privacy Practices.**

Print Patient's Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

### For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Staff Signature \_\_\_\_\_

Date \_\_\_\_\_

### HIPAA Authorization for Release of Protected Health Information

By signing this Authorization, you agree to the release of your Protected Health Information as described in this Authorization. This Authorization is intended to comply with the requirements of the HIPAA Privacy Rule. If you have questions about this Authorization, please contact the Privacy Official for the Dental Practice, noted below. If you agree with this Authorization, please complete it, sign and date it at the end and provide to us.

**Privacy Official:** Dr. Iven Gonzalez, DDS  
**Dental Practice mailing address:** 11240 Montwood Dr. Suite J, El Paso, TX 79936  
**Dental Practice email address:** [suncitydental@live.com](mailto:suncitydental@live.com)  
**Dental Practice phone number:** (915) 201-2539

**Protected Health Information that I am authorizing the Dental Practice to release (Please check the records to which this Authorization applies):**

I authorize Sun City Dental, PLLC and its employees to release the following Protected Health Information:

- Dental reports and notes.
- Dental Images
- All dental records relating to (specify injury or illness): \_\_\_\_\_
- Other(specify): \_\_\_\_\_

**The reason for the release of the Protected Health Information (please check the reason(s) that apply):**

- Patient Request
- Review Patient's current care
- Treatment/continued care
- Payment for care, including insurance

• Please be advised, if you wish we not disclose your PHI to your insurance carrier for purposes of payment to services rendered, payment for services will be due in full the day of the appointment. Request to withhold information from your insurance carrier must be done at your new patient appointment or before treatment commences. It may not be possible to withhold information from your insurance carrier after treatment has commenced or request to share for certain procedures and not for others whether or not procedures were performed the same day, as your insurance carrier may still be able to deduce this information You are still responsible for any balance due as a result of non-payment from your insurance company for services rendered.

- Legal
- Obtaining Social Security Disability or other public benefits
- Other (specify): \_\_\_\_\_

**Your rights with respect to this Authorization:**

It is completely your decision whether or not to sign this Authorization. We cannot refuse to treat you if you choose not to sign this Authorization; however, payments for services will be due in full the day of the appointment.

If you sign this Authorization, you can revoke it prior to the expiration date above by sending a note in writing to the Dental Practice to the address or email address indicated on the first page of this Authorization. The revocation will not have any effect, however, on actions taken in reliance on the Authorization prior to your revocation.

BY MY SIGNATURE, I CERTIFY THAT I HAVE READ AND UNDERSTAND THIS AUTHORIZATION. I AM SIGNING IT VOLUNTARILY. I AUTHORIE THE DISCLOSURE OF MY PROTECTED HEALTH INFORMATION AS DESCRIBED IN THIS AUTHORIZATION.

Please Print Patient's Name \_\_\_\_\_ Date \_\_\_\_\_

Signature of Patient, Parent, Guardian Or Personal Representative \_\_\_\_\_

**Authority of Personal Representative to Sign for the Patient (check one):**

- Parent
- Guardian
- Power of Attorney
- Other: \_\_\_\_\_

Please print name of Parent, Guardian or Personal Representative \_\_\_\_\_