Ria Flores-Tamayo D.D.S., Inc.

Family & Cosmetic Dentistry

14425 W. McDowell Road, Suite F106
Goodyear, Arizona 85395;
www.goodyeardentistry.com

"Healthy Teeth... Healthy Life Style"

Office No.(623)-341-3390; (623)-925-8208
Fax: (623)-925-8108;
Email: dr.ria@goodyeardentistry.com

P A T I E N T I N F O R M A T I O N

Patient Name: _____ _____ _____ Date: _____
First Name **M.I.** **Last Name**

Address: _____ City: _____

State: _____ ZIP Code: _____ Home Phone: (_____) _____ Cell Phone :(____)_____

Employer: _____Work Phone: _____

Date of Birth: _____ Age: _____ Social Security: _____ _____

Patient Referred by: _____ General Dentist: _____ Family Physician: _____

Single: _____ Married: _____ Husband/Wife's Name: _____ _____
First Name Last Name

School (IF Full-Time Student): _____ City:_____

Email:_____

R E S P O N S I B L E P A R T Y I N F O R M A T I O N

Person Responsible for Account: _____ _____ Relationship to Patient: _____
(*If NOT same from Above)*

Address of Responsible Party :_____ City _____ State: _____ ZIP:_____

Employer :_____ Address :_____Phone: (_____) _____

I N S U R A N C E I N F O R M A T I O N

PRIMARY MEDICAL INSURANCE:

Insurance Co.:_____
Policy Holder: _____ _____
First Name Last Name
Relationship to Patient:_____
Social Security Policy Holder:._____
Date of Birth:_____
Group Name/Number: _____/_____
Group Name Group Number
Insurance Address: _____
Street
_____/_____/_____
City State Zip
Insurance Policy Number :(____)_____

PRIMARY DENTAL INSURANCE:

Insurance Co.:_____
Policy Holder: _____ _____
First Name Last Name
Relationship to Patient:_____
Social Security Policy Holder:._____
Date of Birth:_____
Group Name/Number: _____/_____
Group Name Group Number
Insurance Address: _____
Street
_____/_____/_____
City State Zip
Insurance Policy Number :(____)_____

I(We) the undersigned, hereby agree to pay all amounts and charges incurred by myself and members of my family for services rendered by Dr. Flores-Tamayo according to financial policies established.

In the even that Dr.Flores-Tamayo agrees to file insurance claims for myself or my family, I authorize the release of dental information necessary to process that claim and request that payment of benefits be made to Dr. Flores-Tamayo. I further agree to pay any amount not covered by my insurance company.

PATIENT/RESPONSIBLE PARTY SIGNATURE:_____

PLEASE PRINT NAME

PLEASE COMPLETE ALL MEDICAL INFORMATIONON THE

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M E D I C A L H I S T O R Y

PLEASE ANSWER ALL QUESTIONS BY CIRCLING YES (Y) OR NO (N)

1. Are you in good health? Y N
2. Has there been any changes in you general health in the pas year? Y N
3. Date of last physical exam: _____ Y N
4. Are you now under a physician's care for particular problem? Y N
   If yes, for what _____
5. Have you had any serious illness, operations or hospitalizations? Y N

If so, describe (and dates)

6. Have you had any adverse effects from dental treatment? Y N
7. Do you have or have you ever had any of the following: Y N
   a. Congenital heart disease/Mitral valve prolapsed? Y N
      Cardiovascular disease (Heart trouble, heart attack heart murmuring, coronary artery disease, angina, high blood pressure, stroke, palpitations, heart surgery, peacemaker installed)? Y N
   b. Rheumatic fever or rheumatic heart disease? Y N
   c. Lung disease (asthma, emphysema, chronic cough, bronchitis, pneumonia, tuberculosis, shortness of breath, chest pain, severe coughing? Y N
   d. Seizures, convulsions, epilepsy, fainting, psychiatric treatment, dizziness, nervous disorder or breakdown? Y N
   e. Bleeding disorder, anemia, bleeding tendency, blood transfusion, or bruise easily? Y N
   f. Liver disease (jaundice, hepatitis)? Y N
   g. Kidney disease? Y N
   h. Diabetes? Y N
   i. Thyroid disease? Y N
   j. Arthritis? Y N
   k. Stomach ulcers or colitis? Y N
   l. Glaucoma? Y N
   m. Frequent or recurring mouth sores (herpes)? Y N
   n. Implants placed in your body (heart valve, hip, knee)? Y N
   o. Radiation (X-ray) treatment for cancer? Y N
   p. Clicking or popping of jaw joint, pain near ears, difficulty in opening mouth, grind or clench your teeth? Y N
   q. Sinus or nasal problems? Y N
   r. Any disease drugs or transplants operation that may suppress you immune system (HIV/AIDS). Y N
   s. Recurring infections of any kind. Y N

8. Are you ALLERGIC or have a bad reaction to:
   a. Local Anesthesia (Novocaine, etc)? Y N
   b. Penicillin, amoxicillin, cephalosphorine or other antibiotics?
   c. Barbiturates, sedatives, etc? Y N
   d. Aspirin or ibuprofen? Y N
   e. Codeine or other painkillers? Y N
   f. Latex or rubber products? Y N
   g. Other allergies or reactions? Y N

   If yes, please specify:

9. Are you using or taking any of the following MEDICATIONS? Y N
   h. Insulin, diabenese, or similar drug? Y N
   i. Digitalis, inderal, nitroglycerin, calcium blockers, procardia or other heart medication? Y N
   j. Asprin or ibuprofen (motrin, naprosyn, etc)?
      How much daily?_____Y N
   k. Antihistamines or other decongest
   l. Any other medications, pills or drugs, including "street drugs"? Y N

   If yes, please specify:

   M: Tagamet? Y N
   N. Thyroid medications? Y N
   O. Antibiotics or Sulfa drugs? Y N
   P. Anticoagulants/Blood Thinners? Y N
   Q. High Blood pressure medicine? Y N
   R. Steroids, cortisone, etc.? Y N
   S. Tranquilizers (Valium, etc.) Y N
10. Do you wear contact lenses? Y N
11. Do you smoke or chew tobacco? How much daily? ____ Y N
12. Do you use alcohol? How much? _____ Y N
13. Have you ever sought professional care for drug abuse, alcoholism, or emotional disorders? Y N
14. WOMEN: Are you pregnant or planning pregnancy? Y N
    Are you taking any birth control pills? Y N
    Are you taking hormone replacements? Y N
15. Do you have any other disease, condition or problem not listed?
    Here that you think the doctor should know about? Y N
    If yes, please specify: _____
16. Do you wish to talk with the doctor privately about anything? Y N

IF YOU HAVE CIRCLED YES TO ANY OF THE ABOVE, PLEASE GIVE DETAILS AND INCLUDE DATES:

PATIENT RESPONSIBILITIES

In order to achieve optimum results, a cooperative effort is required. Once a treatment plan has been established, it is the patient's responsibility to follow instructions provided involving follow up care and appointment. A mutual respect and consideration between Dr. Flores-Tamayo patients and staff is required to achieve our common goals. I understand the importance of providing a truthful health history to assist my doctor in providing the best care possible. I have the opportunity to discuss my health history with Dr. Flores-Tamayo and the information I have provided hare is complete and accurate.

Patient/Guardian's Signature:_____

Physician's Signature: _____