Lupy D. Gonzalez, D.D.S.
11458 Space Center Blvd.
Houston TX 77059

(281)487-2400

www.clearpointdentistry.com

Patient Information

Please take a moment to enter or update your information to help us ensure the quality of your care is excellent.

Chart #. _____
FOR OFFICE USE ONLY

Patient Name: _____ (Last) _____ (First) _____ (MI) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) Gender: ◯ Male ◯ Female Family Status: ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: _____ Prev. Visit: _____ Email Address: _____

Phone: _____ (Home) _____ (Work) _____ (Ext) _____ (Mobile) Best time to call: _____

Address: _____

_____ (City) _____ (State) _____ (Zip Code)

Whom may we thank for referring you to our practice?

_____

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Spouse or Responsible Party Information

The following is for: * ☐ the patient's spouse ☐ the person responsible for payment ☐ neither-not applicable

Name: * Last * First MI Preferred Name

Title: Mr/Ms/Mrs/etc Gender: * ◯ Male ◯ Female Family Status: * ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: * Email Address:

Phone: * Home Work Ext Mobile Best time to call:

Address: *

* City * State * Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: Phone:

Address:

City State Zip Code

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Primary Insurance Information

Primary Dental Insurance:

Name of Insured: _____ (Last) _____ (First) ____ (MI)

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

Insured's Address: _____ _____

_____ (City) ____ (State) _____ (Zip Code)

Insured's Employer Name: _____

Employer Address: _____ _____

_____ (City) ____ (State) _____ (Zip Code)

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Insurance Address: _____ _____

_____ (City) ____ (State) _____ (Zip Code)

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Secondary Insurance Information

Secondary Dental Insurance:

Name of Insured: _____ (Last) _____ (First) _____ (MI)

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

Insured's Address: _____ _____

_____ _____ _____ (City) (State) (Zip Code)

Insured's Employer Name: _____

Employer Address: _____ _____

_____ _____ _____ (City) (State) (Zip Code)

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Insurance Address: _____ _____

_____ _____ _____ (City) (State) (Zip Code)

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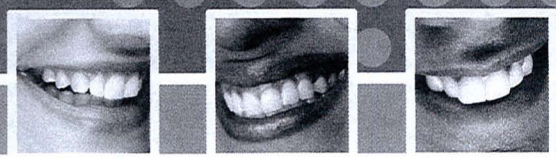

Consent for Services

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed unless other arrangements are made.

Patients with dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that any fee estimate for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment, or within five (5) days of billing if credit is extended. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me to discuss this statement or my treatment.

☐ I have read the above conditions of treatment and payment and agree to their content.

Signature of patient, parent, or guardian (responsible party):

Signature: _____ Date: _____

Relationship to Patient:

_____

Response Date: _____

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Medical & Dental History Form

Patient Name: _____ (Last) _____ (First) _____ (MI) _____ (Preferred Name)

Please take a moment to let us know about your medical and dental history so we may serve you more effectively and in a way that watches out for your overall health and well-being.

Would you consider yourself to be in fairly good health?

◯ Yes ◯ No

Within the past year, have there been any changes in your general health?

◯ Yes ◯ No

What is the date (or approximate date) of your last medical exam?

Your Primary Care Physician's name, address, & phone number:

Please mark any of the following to indicate Yes in response to the question:

☐ Have you ever had complications following dental treatment?

☐ Are you currently under the care of a physician due to a specific condition?

☐ Have you been hospitalized within the last 5 years due to a surgery or illness?

☐ Are you currently taking any prescription or non-prescription medications?

☐ Do you use tobacco (smoking or chewing)?

☐ Do you require the use of corrective lenses (contacts or glasses)?

☐ Do you have any other conditions, diseases, etc., not listed above that we should be aware of?

If any of the previous questions are marked, please explain:

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WOMEN ONLY: Are you pregnant?

◯ Yes ◯ No

If Yes, when is the due date?

Please indicate if you have experienced any of the following:

☐ *Pre-Med - Amox	☐ *Pre-Med - Clind	☐ *Pre-Med - Other	☐ Allergies
☐ Allergy - Aspirin	☐ Allergy - Codeine	☐ Allergy - Erythro	☐ Allergy - Hay Fever
☐ Allergy - Latex	☐ Allergy - Other	☐ Allergy - Penicillin	☐ Allergy - Sulfa
☐ Anemia	☐ Arthritis	☐ Artificial Joints	☐ Asthma
☐ Blood Disease	☐ Cancer	☐ Diabetes	☐ Dizziness
☐ Epilepsy	☐ Excessive Bleeding	☐ Fainting	☐ Glaucoma
☐ Head Injuries	☐ Heart Disease	☐ Heart Murmur	☐ Hepatitis
☐ High Blood Pressure	☐ HIV	☐ Jaundice	☐ Kidney Disease
☐ Liver Disease	☐ Mental Disorders	☐ MVP	☐ Nervous Disorders
☐ Other	☐ Pacemaker	☐ Pregnancy	☐ Radiation Treatment
☐ Respiratory Problems	☐ Rheumatic Fever	☐ Rheumatism	☐ Sinus Problems
☐ Stomach Problems	☐ Stroke	☐ Tuberculosis	☐ Tumors
☐ Ulcers	☐ Venereal Disease		

Do you have any other health issues or allergies?

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What is the reason for your dental visit today?

When was your last visit to the dentist (if to a different office)?

What was done on your last dental visit (if to a different office)?

Prior Dentist's name, address, & phone number:

How frequently do you brush your teeth?

◯ 3 (+) a day ◯ Twice a day ◯ Once a day ◯ Weekly ◯ Seldom

How frequently do you floss your teeth?

◯ 1 (+) a day ◯ 2 - 6 weekly ◯ 1 - 6 monthly ◯ Seldom ◯ Never

Please mark any of the following to indicate Yes in response to the question:

☐ Do your gums bleed when you brush or floss?

☐ Do your teeth experience sensitivity to cold or hot temperatures?

☐ Are any of your teeth currently causing you pain?

☐ Do you grind your teeth (either consciously or during sleep)?

☐ Are any of your teeth loose, or are you concerned about any teeth loosening?

☐ Do you currently have any dental implants, dentures, or partials?

If any of the previous questions are marked, please explain:

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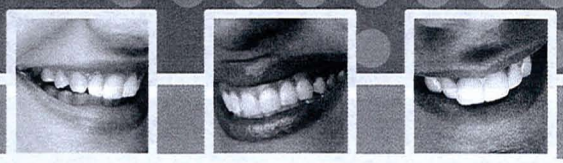

If you could change anything about your mouth, teeth, or smile, what would it be?

☐ To the best of my knowledge, all of the preceding information is true and correct. If I ever have a change in my health, I will inform the office at my next detal appointment without fail.

Authorization

I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health.

I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate.

I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payors, and/or healthcare practitioners. I authorize the payment from my insurance carrier to submit payment directly to the dentist or dental practice to be applied directly to any outstanding balance on my account.

I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance, and I may be billed for this remaining balance. I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependents (if any).

Signature of patient, parent, or guardian:

Signature: _____ Date:

Relationship to Patient:

Response Date:

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RELEASE OF INFORMATION

I authorize release of any information from my medical doctor or previous dentist concerning my medical health and dental treatment.

Do you or have you ever had a drug problem?

◯ Yes ◯ No

I agree to a $75.00 per hour fee due to a no show appointment or cancelling an appointment without giving the office a 24 hour notice.

I certify that the information I have given the Doctor is correct to the best of my knowledge.

Response Date: _____

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FINANCIAL POLICY AND AGREEMENT

In an effort to provide you with quality dental care, we have expanded our payment policy. We will use our expertise to help you obtain the maximum benefits from your insurance policy. We expect full payment when services are rendered unless prior arrangements have been made.

PLEASE SELECT DESIRED PAYMENT METHODS

_____ Payment by cash or check
_____ Automatic billing to your Visa, Mastercard, American Express, Discover or Carecredit
_____ 3rd party dental financing plan, we will assist you in applying for financing should you desire

INSURANCE: We will file your insurance claims. You are expected to pay in full if we cannot verify your insurance coverage at the time of service. After 30 days, any unpaid balance will accrue 1.5% monthly interest.

CHARGES: You will be responsible for all insurance deductibles and copayments at time of service. The remaining balance of charges not paid by insurance need to be paid within 30 days of the date of service.

BROKEN APPOINTMENTS: We reserve the right to charge $75.00 per hour for each failed appointment without a 24 hour notice.

I assign my insurance benefits to the provider listed above. I understand this form is a valid financial agreement. I certify that I have read and understand the above information.

Signature: _____ Date: _____

Response Date: _____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

By signing below I acknowledge that I have received or reviewed the Notice of Privacy. I agree with the terms of this notice and understand my rights under this notice. By signing below I consent for the use of my personal health information for treatment, payments, operations and other uses as described in the privacy notice. I also understand that I have the right not to sign this agreement.

Name _____

Signature _____

Relationship to patient _____

Date _____

If we are unable to get your acknowledgement then our office will make a notation as to reason why it was not obtained.

Signature: _____ Date: _____

Reason why acknowledgement was not obtained

_____

Staff Name _____

Signature _____

Date _____

Response Date: _____