JOYCE GUNAWAN, D.D.S.
ALFONSO NAVARRETE, D.D.S.
GENERAL DENTISTRY & ORTHODONTICS

1636 B Street, Hayward, CA 94541
510-538-9800 (tel), 510-751-4837 (fax)
Email: gunawan.dds@gmail.com

Name_____ Date of Birth_____ Age_____
Last First M.I.

Address_____ City_____ State_____ Zip_____

Email Address_____ Home Phone_____ Cell Phone_____

Social Security #_____ Occupation_____ Business Phone_____

MEDICAL HISTORY

Referring Person_____ Previous Dentist_____ How Long with this dentist_____
Medical Doctor_____ Telephone_____

Are you under a doctor's care now? ☐ Yes ☐ No Nature Of Treatment_____

Have you EVER had any of the following? Please check each box.

	YES	NO		YES	NO		YES	NO		YES	NO
High Blood Pressure			Mitral Valve Prolapse			Tuberculosis			Diabetes		
Heart Attack			Heart Valve Replacement			Hepatitis			Thyroid Disease		
Stroke			Artificial Joint			Cancer			Epilepsy		
Arrhythmias			Asthma			Liver Disease			Nervous Disorder		
Pace Maker			Abnormal Bleeding			Kidney Disease			Blood Transfusion		
Heart Disease			Sinus Problems			Arthritis			AIDS/HIV Positive		
Heart Murmur			Lung Disease			Ulcers			Drug Dependency		

Other medical concerns: _____

Are you currently taking any of the following? Please check each box.

	YES	NO		YES	NO		YES	NO
Antibiotics			Aspirin			Thyroid Medication		
High Blood Pressure			Anticoagulants (blood thinners)			Steroids		
Heart Medications			Antidepressants			Pain Medications		
Birth Control Medications			Sedatives (Valium, Xanax)			Other Medications		
Cancer Medication			Insulin/Other Diabetic Drugs					

List names of the medication and dosage you are currently taking: _____

_____

Are you now taking, or have you ever taken Fosamax, Bonica, Actonel, Skelid, or Didronel? . . . . . ☐Yes ☐No

Have you ever had intravenous Aredia or Zometa for cancer treatment? . . . . . ☐Yes ☐No

Are you sensitive or allergic to any of the following? Please check each box.

	YES	NO		YES	NO		YES	NO
Local anesthetics			Sulfa			Codeine		
Penicillin/Amoxicillin			Ibuprofen			Latex Products		
Clindamycin			Aspirin			Other Medications		

What type of reaction did you have? _____
Female Patients: Are you pregnant? ☐ Yes ☐ No If yes, what trimester? _____
Are you taking oral contraceptives? . . . . . ☐ Yes ☐ No
Have you ever taken Fen-Phen? (Weight loss) . . . . . ☐ Yes ☐ No
To the best of my knowledge, all the above answers are true and correct. I will inform the doctor of changes in my health history.

Patient's signature_____ Date_____ Reviewed_____

Patient's signature_____ Updated_____ Reviewed_____

FINANCIAL INFORMATION

PERSON RESPONSIBLE FOR THIS ACCOUNT

Name_____ Relationship to Patient_____
Last First Middle

Address_____ City/State_____ Zip_____ Phone_____
Social Security Number_____ Cell phone_____
Employer_____ Business Address_____
Business Phone Number_____ How long employed by this firm?_____

DENTAL INSURANCE - If you have any Dental Insurance, please fill in the following:

Employee's Name_____ Relationship to Patient_____ Birth date_____
Social Security Number_____ Employer_____
Name of Insurance_____ Group # or Union Local #_____ Bus. Phone_____

If you have a second Dental insurance plan, please fill in the following:
Employee's Name_____ Relationship to Patient_____ Birth date_____
Social Security Number_____ Employer_____
Name of Insurance_____ Group # or Union #_____
Insurance Co. Address_____
Insurance Co. Telephone_____

You are responsible for payment of your account. Payment is due at the time of treatment. If you have insurance, your co-payment us due at the time of treatment. As a courtesy, we will submit your insurance forms. A $50.00 administrative fee will be assumed on all delinquent accounts sent to collections. A $25.00 charge will be assessed to your accounts for returned checks. For broken appointments and late cancellations (less than 24 hours), a $50 charge will be applied to your account. A 1.5% finance charge will be assessed per month for outstanding balances over 60 days.

I acknowledge full responsibility for the payment of the dental services to be rendered.

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance with _____ and assign directly to the office of Dr. Joyce Gunawan and D. Alfonso Navarrete, if any, otherwise payable to me for services rendered. I hereby authorized the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

Signed_____ Date_____
Patient, Parent, or Agent (must be 18 years or older)