JOYCE GUNAWAN, D.D.S.

GENERAL DENTISTRY

1636 B Street, Hayward, CA 94541
510-538-9800 (tel), 510-751-4837 (fax)
hooray4teeth@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: ________________________________

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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)