

Welcome to our Practice

PATIENT INFORMATION:

Today's Date 10/20/2025

☒ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. First Name Gerson M.I. R Last Name Turcios
Sex: ☒ Male ☐ Female Birth Date 10/11/2004 Age 21 Soc. Sec. # _____ E-mail Greensonic54321@gmail.com
Street 5000 Fort Totten Dr NE Apt. 304 City Washington State DC Zip 20011
Home Tel. (202) 569-5702 Cell. (202) 569-5702 Have you ever been a patient of our practice? ☐ Yes ☒ No
Referred By Marlo Turcios Has a family member ever been a patient of our practice? ☒ Yes ☐ No
Dentist _____ Orthodontist _____
Medical Dr. _____ Preferred Pharmacy _____ Tel. (_____) _____
Driver's Lic.# _____ Nearest relative not living with you _____ Tel. (_____) _____
Employer _____ Bus. Tel. (_____) _____ Personal Payment Type: ☐ Cash ☐ Check ☐ Credit Card
In case of emergency, please contact Yesenia Turcios Tel. (202) 468-0196 Relation Mother

WHO WILL BE RESPONSIBLE FOR YOUR ACCOUNT:

☐ Self (If self, skip this section) ☐ Spouse ☐ Father ☐ Mother ☒ Other Brother
Name Marlo Turcios S.S.# _____ Birth Date 07/22/2002 Age 23
Tel. (_____) - _____ Cell. (202) 569-5308 E-mail _____
Street 5000 Fort Totten Dr NE Apt. 304 City Washington State DC Zip 20011
Driver's Lic.# _____ Employer _____ Bus. Tel. (_____) _____

SPOUSE OR OTHER GUARANTOR INFORMATION: (IF DIFFERENT FROM ABOVE)

Name _____ Relation _____ S.S.# _____ Birth Date _____
Street _____ Apt. _____ City _____ State _____ Zip _____
Tel. (_____) _____ Employer _____ Bus. Tel. (_____) _____

INSURANCE INFORMATION:

Student: ☒ Full Time ☐ Part Time ☐ Not School Name and Address Catholic University of 620 Michigan Ave NE
Marital Status: . ☐ Married ☐ Divorced ☐ Widow ☒ Single ☐ Legally Separated Washington DC 20064
Employed: ☐ Full Time ☐ Part Time ☐ Retired ☒ Not Do you belong to a PPO or HMO? ☐ Yes ☒ No

PRIMARY DENTAL INSURANCE COMPANY:

Employer AmeriHealth Caritas
Bus. Address 1207 Taylor St NW, Washi Washington DC 20011
Bus. Tel. (202) 408-4720 Plan AmeriHealth Caritas
Ins. Co. Name AmeriHealth Caritas I.D. # 70530727
Address 1207 Taylor St NW, Washi Washington DC 20011
Tel. (202) 408-4720 Group Name _____
Group # 90906873 Insured Party _____
Relation _____ Birth Date _____ Sex: ☐ M ☐ F
S.S. # _____ Tel. (_____) _____
Address 5000 Fort Totten Dr NE Washington DC 20011

SECONDARY DENTAL INSURANCE COMPANY:

Employer _____
Bus. Address _____
Bus. Tel. (_____) _____ Plan _____
Ins. Co. Name _____ I.D. # _____
Address _____
Tel. (_____) _____ Group Name _____
Group # _____ Insured Party _____
Relation _____ Birth Date _____ Sex: ☐ M ☐ F
S.S. # _____ Tel. (_____) _____
Address _____

PRIMARY MEDICAL INSURANCE COMPANY:

Employer AmeriHealth Caritas
Bus. Address 1207 Taylor St NW, Washi Washington DC 20011
Bus. Tel. (202) 408-4720 Plan AmeriHealth Caritas
Ins. Co. Name AmeriHealth Caritas I.D. # 70530727
Address 1207 Taylor St NW, Washi Washington DC 20011
Tel. (202) 408-4720 Group Name _____
Group # 90906873 Insured Party _____
Relation _____ Birth Date _____ Sex: ☐ M ☐ F
S.S. # _____ Tel. (_____) _____
Address 5000 Fort Totten Dr NE Washington DC 20011

SECONDARY MEDICAL INSURANCE COMPANY:

Employer _____
Bus. Address _____
Bus. Tel. (_____) _____ Plan _____
Ins. Co. Name _____ I.D. # _____
Address _____
Tel. (_____) _____ Group Name _____
Group # _____ Insured Party _____
Relation _____ Birth Date _____ Sex: ☐ M ☐ F
S.S. # _____ Tel. (_____) _____
Address _____

HEALTH HISTORY:

To our patients: Although oral surgeons primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have, or medications that you may be taking, could have an important interrelationship with the care that you will be receiving. Thank you for answering the following questions. Your answers are for our records only and will be considered confidential.

Reason for today's office visit? Wisdom Teeth Removal

- | | Yes | No |
|--|-------------------------------------|-------------------------------------|
| 1. Height <u>6'1</u> Weight <u>198</u> Are you in good health? | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 2. Have there been any changes in your general health in the past year? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 3. Are you under the care of a physician? Date of last visit | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| If so, for what are you being treated? | | |
| 4. Have you had any illness, operation or been hospitalized in the past five years? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| If so, describe | | |
| 5. Do you have unhealed / recurrent injuries or inflamed areas, growths or sore spots in or around your mouth? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| If so, describe where | | |
| 6. Do you have a prosthetic joint / implant? If so, describe where | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 7. Have you had a heart valve replacement or vascular graft? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 8. Have you ever had general anesthesia or IV sedation? | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 9. Have you, or a family member, had any unusual or serious reactions to general anesthesia or IV sedation? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 10. Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |

HAVE YOU EVER HAD, OR DO YOU CURRENTLY HAVE:	YES	NO	NOTES
11. Rheumatic fever?		<input checked="" type="checkbox"/>	
12. Damaged heart valves / mitral valve prolapse?		<input checked="" type="checkbox"/>	
13. Heart murmur?		<input checked="" type="checkbox"/>	
14. High blood pressure?		<input checked="" type="checkbox"/>	
15. Low blood pressure?		<input checked="" type="checkbox"/>	
16. Chest pain / angina?		<input checked="" type="checkbox"/>	
17. Heart attack(s)?		<input checked="" type="checkbox"/>	
18. Irregular heart beat?		<input checked="" type="checkbox"/>	
19. Cardiac pacemaker?		<input checked="" type="checkbox"/>	
20. Heart surgery?		<input checked="" type="checkbox"/>	
21. Pneumonia, bronchitis, chronic cough?		<input checked="" type="checkbox"/>	
22. Asthma?		<input checked="" type="checkbox"/>	
23. Hay fever / sinus problems?		<input checked="" type="checkbox"/>	
24. Snoring?		<input checked="" type="checkbox"/>	
25. Sleep apnea / CPAP?		<input checked="" type="checkbox"/>	
26. Difficult breathing / other lung trouble?		<input checked="" type="checkbox"/>	
27. Tuberculosis?		<input checked="" type="checkbox"/>	
28. Emphysema?		<input checked="" type="checkbox"/>	
29. Do you smoke or vape? If so, how much a day _____		<input checked="" type="checkbox"/>	
30. Do you use chewing tobacco?		<input checked="" type="checkbox"/>	
31. Alcohol intake? If so, drinks per Day _____ Week _____		<input checked="" type="checkbox"/>	
32. Blood transfusion?		<input checked="" type="checkbox"/>	
33. Blood disorder such as anemia?		<input checked="" type="checkbox"/>	
34. Bruise easily?		<input checked="" type="checkbox"/>	
35. Bleeding tendency / abnormal bleed?		<input checked="" type="checkbox"/>	
36. Hepatitis, jaundice, or liver disease?		<input checked="" type="checkbox"/>	
37. Infectious mononucleosis?		<input checked="" type="checkbox"/>	
38. Gallbladder trouble?		<input checked="" type="checkbox"/>	
39. Fainting spells?		<input checked="" type="checkbox"/>	

HAVE YOU EVER HAD, OR DO YOU CURRENTLY HAVE:	YES	NO	NOTES
40. Convulsions / epilepsy?		<input checked="" type="checkbox"/>	
41. Stroke?		<input checked="" type="checkbox"/>	
42. Thyroid trouble?		<input checked="" type="checkbox"/>	
43. Diabetes?		<input checked="" type="checkbox"/>	
44. Low blood sugar?		<input checked="" type="checkbox"/>	
45. Kidney trouble?		<input checked="" type="checkbox"/>	
46. High cholesterol?		<input checked="" type="checkbox"/>	
47. Are you on dialysis?		<input checked="" type="checkbox"/>	
48. Swollen ankles / arthritis / joint disease?		<input checked="" type="checkbox"/>	
49. Osteoporosis / osteopenia?		<input checked="" type="checkbox"/>	
50. Osteonecrosis?		<input checked="" type="checkbox"/>	
51. Stomach ulcer / acid reflux?		<input checked="" type="checkbox"/>	
52. COVID-19?		<input checked="" type="checkbox"/>	
53. Contagious diseases?		<input checked="" type="checkbox"/>	
54. Sexually transmitted diseases?		<input checked="" type="checkbox"/>	
55. Problems with immune system? Possibly from medication / surgery, etc.		<input checked="" type="checkbox"/>	
56. Autoimmune disease?		<input checked="" type="checkbox"/>	
57. Delay in healing?		<input checked="" type="checkbox"/>	
58. A tumor or growth?		<input checked="" type="checkbox"/>	
59. Cancer / radiation therapy / chemotherapy?		<input checked="" type="checkbox"/>	
60. Chronic fatigue / night sweats?		<input checked="" type="checkbox"/>	
61. Are you on a diet?		<input checked="" type="checkbox"/>	
62. Is there a history / treatment for an alcohol use disorder?		<input checked="" type="checkbox"/>	
63. Is there a history / treatment for a marijuana or substance use disorder?		<input checked="" type="checkbox"/>	
64. Contact lenses?		<input checked="" type="checkbox"/>	
65. Eye disease / glaucoma?		<input checked="" type="checkbox"/>	
66. Mental health problems / anxiety / depression?		<input checked="" type="checkbox"/>	
67. A removable dental appliance?		<input checked="" type="checkbox"/>	
68. Pain or clicking of jaws when eating?		<input checked="" type="checkbox"/>	

WOMEN ONLY: (QUESTIONS 69–72)

69. Is there a possibility of pregnancy? ☐ ☐

70. Expected delivery date?_____

71. Are you nursing? ☐ ☐

72. Are you taking birth control pills?..... ☐ ☐

Note: Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician / gynecologist for assistance regarding other methods of birth control.

[illegible]

Is there any condition concerning your health that the Doctor should be told about? ☐ Yes ☒ No – If Yes, describe

--

Do you wish to speak to the Dr. privately about anything? ☐ Yes ☒ No

[illegible]

Is there a family history of:

☐ Cancer ☐ Diabetes ☐ Heart disease ☐ Anesthesia problems

Is this visit related to an accident? ☐ Yes ☒ No

If Yes, what type of accident? ☐ Automobile ☐ Work related ☐ Other

Date of injury _____

Insurance company handling the claim_____

Claim number

Name of attorney / adjustor

Telephone number ()

I **certify** that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my doctor, or any other member of his / her staff, responsible for any errors or omissions that I have made in the completion of this form.

X Gerson Turcios X 10/20/2025 X _____
Signature of patient (Parent or Guardian if Minor) Date Reviewed by Date

POLICY FOR APPOINTMENTS INVOLVING SURGERY

The day of your appointment, if you are having surgery, there may be driving and / or eating restrictions. The office will review this information with you prior to your procedure. I acknowledge that I have read and I understand the policy above.

X Gerson Turcios X 10/20/2025
Signature of patient (Parent or Guardian if Minor) Date

FEES & PAYMENTS

We make every effort to keep down the cost of your care. You can help by paying upon completion of each visit. Other arrangements can be made with our office manager depending upon special circumstances. An estimate of the charge for any procedure or surgery you may require will be given to you upon request. If you have any dental and/or medical insurance we will be glad to fill out the proper forms, but please complete the identifying information on this form.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. **It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance company.** You will be responsible for all collection costs, attorneys fees, and court costs.

X Gerson Turcios X 10/20/2025
Signature of patient (Parent or Guardian if Minor) Date

This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to this doctor named of the benefits otherwise payable to me.

X Gerson Turcios X 10/20/2025
Signature of patient: (Parent or Guardian if Minor) Date

AUTHORIZATION

I authorize my surgeon and his / her designated staff, to perform an oral and maxillofacial examination, for the purpose of diagnosis and treatment planning. Furthermore, I authorize the taking of all x-rays required as a necessary part of this examination. In addition, if medically necessary, I authorize the release of any information acquired in the course of my examination and treatment to my other doctors and/or insurance carriers. I permit messages to be left on my phone and / or mobile phone concerning my appointment

☒ I permit the office to communicate with me via text message on my cell phone.

X Gerson Turcios X _____ X 10/20/2025
Signature of patient (Parent or Guardian if Minor) Doctor Date

I hereby acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice.

X Gerson Turcios X 10/20/2025
Signature of patient (Parent or Guardian if Minor) Date

Attached Files:

image0 (4), image1 (4), image3, image2