Patient Information

Patient Name: (NOMBRE) _____ Date(*FECHA*)_____.
Last, First MI (Preferred Name)
Sex (SEXO) _____ Family Status (estado civil) M__S__D__

Social Security # *:(SEGURO SOCIAL)* _____ Birth Date: (FECHA DE NACIMIENTO) _____

Home phone (CASA) _____**Cell** (**celular**) _____
Place of work _____ **Work phone** (trabajo)_____

Address: (DIRECCION) _____
Street Apartment #
City _____ State _____ Zip Code_____

**** E-MAIL _____

Health Information

Date of Last Dental Visit: _____ Reason for this visit: _____

Have you ever had any of the following? Please check those that apply:

☐ AIDS -SIDA
☐ Allergies-Alergias
☐ Anemia - Anemia
☐ Arthritis- Artritis
☐ Artificial Joints-
☐ Asthma- Asma
☐ Blood Disease-Enfermedades de la sangre
☐ Cancer
☐ Diabetes- Diabetis
☐ Dizziness- Mareos
☐ Epilepsy- Epilepsia
☐ Excessive Bleeding-Sangramiento excesivo
☐ Fainting-Desmayos
☐ Glaucoma
☐ Growths-Tumores
☐ Fever-Fiebre
☐ Head Injuries-Lesiones en la cabeza
☐ Heart Disease-Problemas del corazon
☐ Heart Murmur – Soplo en el Corazon
☐ Hepatitis
☐ High Blood Pressure-Presion alta
☐ Jaundice-
☐ Kidney Disease-Enfermedades Renales
☐ Liver Disease-Enfermedades Hepaticas
☐ Mental Disorders-Trastornos Mentales-
☐ Nervous Disorders-Trastornos Nerviosos
☐ Pacemake-Marcapasos
☐ Pregnancy-Embarazo Due date:_____
☐ Radiation Treatment-Radiaciones
☐ Respiratory Problems-Problemas Respiratorios
☐ Rheumatic Fever-Fiebre Reumatica
☐ Rheumatism-Reumatismo
☐ Sinus Problems-Problemas Nasales
☐ Stomach Problems-Problemas Estomacales
☐ Stroke
☐ Tuberculosis
☐ Tumors
☐ Ulcers- Ulceras
☐ Venereal Disease-Enfermedades Venereas
☐ Codeine Allergy-Alergia a la **Codeina**
☐ Penicillin Allergy-Alergia a la **Penicilina**
OTHER:
☐ _____
☐ _____

- Have you ever had any complications following dental treatment? Ha tenido usted o tiene alguna complicacion dental
  ☐ Yes/Si ☐ No?No
  If yes, please explain: Si es Si, explique cual: _____

- Have you been admitted to a hospital or needed emergency care during the past two years? Ha estado hospitalizado, ha tenido alguna enfermedad grave o lo han operado en los ultimos dos años? ☐ Yes/ Si ☐ No/No
  If yes, please explain: Si es SI, explique : _____

- Are you now under the care of a physician? Esta bajo algun cuidado medico? ☐ Yes/SI ☐ No/No
  If yes, please explain: _____

- Name of Physician: Nombre del medico _____ Phone: _

- Do you have any health problems that need further clarification?Tiene usted alguna condicion medica que necesite aclarar
  ☐ Yes/SI ☐ No/NO
  If yes, please explain:Si es SI, explique _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail
.En mi conocimiento toda la informacion y respuestas anteriormente proporcionadas, son verdaderas y correctas. Si hay algun cambio en mi salud le comunicare de inmediato al medico.

_____ Date: _____
Signature of patient, parent or guardian Firma del paciente o el guardian

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE_____

QUIEN LO REFIRIO A LA OFICINA_____