Dental Land Patient Registration and History Form

PATIENT INFORMATION

Patient Name:______________________ Age:__________ DOB:__________
Nombre de Paciente *Edad* *Fecha de Nacimiento*

Sex Male/Female SS#__________________ Address:______________________
Sexo masculino/femenino *Dirección*

City:____________________ State____________ Zip__________
Ciudad *Estado* *Código Postal*
PH:____________________ Mobile:____________________
Teléfono Numero de Celular

Emergency Contact Name:____________________ PH:____________________
En caso de emergencia *Telephono*
Relationship to patient:____________________
Relación

INSURANCE INFORMATION

Do you have any Dental Insurance Yes No Medicaid Yes No Chip Yes No
Tienes algún seguro Dental

Name:____________________ Address:____________________
Nombre *Dirección*

Subscriber Name:____________________ DOB:__________ SS#__________
Nombre de suscritor
ID:______________ Group#______________ Employer:____________________
Nombre de Empleado
Is the patient the subscriber Yes No Other:____________________
El paciente el suscriptor Si No Otro

ASSIGNMENT AND RELEASE

I certify that I and/or my dependent(s) have insurance coverage with________________ and assign directly to Dr. ________________ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-names dentist may use my health care information and may disclose such information to the above-names Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

____
Signature of Patient, Parent, Guardian, or Personal Representative *Date*

____
Please Print name of Patient, Parent, Guardian, or Personal Representative *Date*

DENTAL HISTORY

Reason for today's ______________________________
Razon de su visita
Mark Yes or No to the following questions: (Marque sí o No a las siguientes preguntas)

Bleeding gums **Yes No** **Sensitivity to Cold** **Yes No** **Dry Mouth** **Yes No**
Sangrado de las encías *Sensibilidad al frío* *Sequedad en la boca*

Grinding Teeth **Yes No** **Sensitivity to Hot** **Yes No** **Broken Fillings** **Yes No**
Rechinar dientes *Sensibilidad al calor* *Rellenos rotos*

Loose Teeth **Yes No** — *Dientes flojos*

TMJ Pain **Yes No** — *Dolor en la mandíbula*

Sores/ growth in mouth Yes No — *Llagas/crecimiento en boca*

How often do you floss? ____________________
¿Con qué frecuencia usar hilo dental?

How often do you brush? ____________________
¿Con que frequecia se lava los dientes?

Date of last visit ________________________

Fecha de Ultima visita de Dentista____________________

HEALTH HISTORY

Circle either "Yes" or "No" to indicate if you have had any of the following:
Marke Si o No en las siguente preguntas

AIDS/HIV Sida/HIV	Yes	No	Epilepsy *Epilepsia*	Yes	No	Sinus Trouble *Problemas del seno*	Yes	No
Anemia *Anemia*	Yes	No	Fainting or dizziness *Desmayos o mareos*	Yes	No	Stroke *Derrame o infarto*	Yes	No
Arthritis, Rheumatism Artritis, reumatismo	Yes	No	Glaucoma *Glaucoma*	Yes	No	Thyroid Problems *Problemas de la tiroides*	Yes	No
Artificial Heart Valves Válvulas cardíacas artificiales	Yes	No	Headaches Dolor de cabeza	Yes	No	Tonsillitis *Amigdalitis*	Yes	No
Artificial Joints *Articulaciones artificiales*	Yes	No	Heart Murmur *Soplo en el corazón*	Yes	No	Tuberculosis *Tuberculosis*	Yes	No
Asthma Asma	Yes	No	Heart Problems Problemas del corazón	Yes	No	High Blood Pressure Presión arterial alta	Yes	No
Bleeding abnormally Sangrado anormal	Yes	No	Kidney Disease Enfermedad del riñón	Yes	No	Shortness of Breath Dificultad para respirar	Yes	No
Extractions or surgery Extracciones o cirugía	Yes	No	Liver Disease Enfermedad del hígado	Yes	No	Emphysema Enfisema	Yes	No
Blood disease Enfermedad de la sangre	Yes	No	Mitral Valve Prolapse Prolapso de válvula mitral	Yes	No	Rheumatic Fever Fiebre reumática	Yes	No
Cancer Cancer	Yes	No	Pacemaker Marcapasos	Yes	No	Diabetes Emphysema Diabetes enfisema	Yes	No
Chemotherapy Quimioterapia	Yes	No	Radiation Treatment Tratamiento de radiación	Yes	No	Respiratory Disease Enfermedades respiratorias	Yes	No
Congenital Heart Lesions Lesiones congénitas del corazón	Yes	No	Pregnant Embarazada	Yes	No			

How many months?_________ Cuantos Meses?____________

ALLERGIES

______ Asprin (Aspirina)
______ Sulfa
______ Penicillin (Penicilina)
______ Iodine (Yodo)
______ Codeine (Codeína)
______ Other (otro)
______ Latex (Látex)
______ Local Anesthetic (Anestésico local)

List of Medications you are taking:
Lista de medicamentos que está tomando:
____
____
____

How did you hear about our office?____

Signature:____ **Date:**______________