ELITE ORTHODONTICS CENTER, LLC

REGISTRO del PACIENTE

Nombre: ______________________ **Apellido:** ______________________ **Middle Initial:** ______

Información del Paciente

Dirección: ____ Apt#: ________

Ciudad, Estado, Zipcode: ____

Casa #: ______________ Trabajo #: ______________ Ext: _____ Celular #: ______________

Sexo: ☐ Hombre ☐ Mujer

Fecha Nacimiento: ______________ Edad: ______ Soc. Sec. #: ______________

Numero de Licencia: ______________

Correo Electrónico: ______________________

☐ Me Gustaria Recivir Correspondencia por Correo Electrónico.

Section 2:

Situación Laboral: ☐ Full-Time ☐ Part-Time ☐ Jubilado

Student Status: ☐ Full-Time ☐ Part-Time

Medicaid ID: ______________

Dentista de Preferencia: ______________

Farmacia de Preferencia: ______________

Paciente es: ☐ Tomador del Seguro ☐ Parte Responsable

Section 3

Referiro por: ______________

Dentista Anterior: ______________

En Caso de Emergencia Llamar: ______________

Contacto de Emergencia Casa #: ______________

Contacto de Emergencia Trabajo #: ______________

Parte Responsable (Si alguien que no sea el paciente)

Nombre: ______________________ Apellido: ______________________ Middle Initial: _____

Dirección: ____ Apt#: ________

Ciudad, Estado, Zipcode: ____

Casa #: ______________ Trabajo #: ______________ Ext: _____ Celular: ______________

Fecha Nacimiento: ______________ Soc. Sec. #: ______________ Numero de Licencia: ______________

☐ Responsable es también titular de la póliza para el paciente ☐ Primaria titular de la póliza de seguro

Información de Aseguransa Primaria

Nombre del Asegurado: ______________________

Relación con el Asegurado: ☐ Self ☐ Esposa ☐ Hijo ☐ Otro

Soc. Sec. # del Asegurado: ______________ Fecha de Nacimiento del Asegurado: ______________

Empleado: ______________________ Compania de Aseguransa: ______________________

Dirección: ______________________ Dirección: ______________________

Ciudad, Estado, Zip: ______________________ Ciudad, Estado, Zip: ______________________

Ha quien le podemos dar las gracias por referirnos?

☐ Amigo/Paciente ☐ Panfletos/Cupon ☐ La Compana de Seguros ☐ Pagínas Amarillas ☐ Radio

☐ Períodico ☐ Nuestro Empleado ☐ Otro ______________________

TIME ______________________ Elite Orthodontics Center, LLC DATE ____________

MEDICAL HISTORY
FOR

Birth Date: ______________________

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: ______________________

Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: ______________________

Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: ______________________

Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: ______________________

Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No ______________________

Are you on a special diet? ◯ Yes ◯ No ______________________

Do you use tobacco? ◯ Yes ◯ No

Do you use controlled substances? ◯ Yes ◯ No

Women: Are you
- ☐ Pregnant/Trying to get pregnant?
- ☐ Nursing?
- ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics

☐ Other If yes, please explain: ______________________

Do you have, or have you had, any of the following?

☐ AIDS/HIV Positive	☐ Chest Pains	☐ Frequent Headaches	☐ Irregular Heartbeat	☐ Scarlet Fever
☐ Alzheimer's Disease	☐ Cold Sores/Fever Blisters	☐ Genital Herpes	☐ Kidney Problems	☐ Shingles
☐ Anaphylaxis	☐ Congenital Heart Disorder	☐ Glaucoma	☐ Leukemia	☐ Sickle Cell Disease
☐ Anemia	☐ Convulsions	☐ Hay Fever	☐ Liver Disease	☐ Sinus Trouble
☐ Angina	☐ Cortisone Medicine	☐ Heart Attack/Failure	☐ Low Blood Pressure	☐ Spina Bifida
☐ Arthritis/Gout	☐ Diabetes	☐ Heart Murmur	☐ Lung Disease	☐ Stomach/Intestinal Disease
☐ Artificial Heart Valve	☐ Drug Addiction	☐ Heart Pace Maker	☐ Mitral Valve Prolapse	☐ Stroke
☐ Artificial Joint	☐ Easily Winded	☐ Heart Trouble/Disease	☐ Pain in Jaw Joints	☐ Swelling of Limbs
☐ Asthma	☐ Emphysema	☐ Hemophilia	☐ Parathyroid Disease	☐ Thyroid Disease
☐ Blood Disease	☐ Epilepsy or Seizures	☐ Hepatitis A	☐ Psychiatric Care	☐ Tonsillitis
☐ Blood Transfusion	☐ Excessive Bleeding	☐ Hepatitis B or C	☐ Radiation Treatments	☐ Tuberculosis
☐ Breathing Problem	☐ Excessive Thirst	☐ Herpes	☐ Recent Weight Loss	☐ Tumors or Growths
☐ Bruise Easily	☐ Fainting Spells/Dizziness	☐ High Blood Pressure	☐ Renal Dialysis	☐ Ulcers
☐ Cancer	☐ Frequent Cough	☐ Hives or Rash	☐ Rheumatic Fever	☐ Venereal Disease
☐ Chemotherapy	☐ Frequent Diarrhea	☐ Hypoglycemia	☐ Rheumatism	☐ Yellow Jaundice

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes, please explain: ______________________

Comments: ______________________

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To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN ______________________ DATE ____________