Patient Information Sheet

Office:

Patient Information

Language: ☐English ☐Spanish Gender: ☐Female ☐Male

Marital Status: ☐Single ☐Married ☐Divorce ☐Widowed ☐Other

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

SSN #: _____ Date of Birth: _____

Home #: _____ Work #: _____

Cell #: _____ Texting OK? ☐Yes ☐No

E-Mail Address: _____

Preferred method of communication

☐ Home Phone ☐ Work Phone ☐ Mobile Phone ☐ Email

Responsible Party

Relationship to patient: ☐Self ☐Guardian/Parent ☐Spouse ☐Other

Gender: ☐Female ☐Male

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

SSN #: _____ Date of Birth: _____

Home #: _____ Work #: _____

Cell #: _____ Texting OK? ☐Yes ☐No

E-Mail Address: _____

Employer Information

Employment Status: ☐Employed ☐Student ☐Retired ☐Unemployed

Employer/School Name: _____

Occupation: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ How long? __Year(s) __Month(s)

Emergency Contact

Relationship to patient: ☐Responsible Party ☐Other

Gender: ☐Female ☐Male

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home #: _____ Work #: _____

Cell #: _____

Physician Name Phone #:

Patient Name: _____

Chart # _____ **Date:** _____

Primary Insurance Information

Insurance Type: ☐No Insurance ☐HMO ☐PPO/Indemnity ☐Denti-Cal

Plan Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone #: _____

Insurance ID # _____ Policy # /Group # _____

Subscriber's Information (Primary Member)

Relationship to patient: ☐Self ☐Responsible Party ☐Spouse ☐Other

Gender: ☐Female ☐Male

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

SSN #: _____ Date of Birth: _____

Employer: _____

Secondary Insurance Information

Insurance Type: ☐No Insurance ☐HMO ☐PPO/Indemnity ☐Denti-Cal

Plan Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone #: _____

Insurance ID # _____ Policy # /Group # _____

Subscriber's Information (Primary Member)

Relationship to patient: ☐Self ☐Responsible Party ☐Spouse ☐Other

Gender: ☐Female ☐Male

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

SSN #: _____ Date of Birth: _____

Employer: _____

How did you hear about us?

☐ 1-800-Dentist ☐ Flyer/Ad ☐ Insurance /Plan Referral: _____

☐ Sign/Building ☐ Marketing Representative: _____

☐ Yellow Pages ☐ Employer ☐ DDS Referral: _____

☐ Family/Friend ☐ Website ☐ Other _____

I hereby certify that the above information is accurate and may be relied upon for granting credit and providing dental services. I understand that I am financially responsible for the charges not covered by or paid for by my insurance company. I hereby authorize payment directly to this professional dental corporation any insurance benefits otherwise payable to me. I understand that I am financially responsible for any charges not covered by this authorization. I authorize release of any information relating to any dental claim or claims.

_____ _____

Signature of Responsible Party Date

(Parent or Legal Guardian if patient is a minor)

Patient Information Update *Update is noting no major change in Patient Information

Date	Signature	Comments

Patient name: _____ **Chart #:** _____	Montebello Children's Dentistry 235 E Beverly Blvd Montebello CA 90640 **Phone:** 323-597-1195 **Fax:** 323-597-1176

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT AND CONSENT

SECTION A: PATIENT INFORMATION

Patient Name

Street Address | Social Security Number

City, State, Zip Code | Telephone

SECTION B: TO THE PATIENT - PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry our treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected heath information and of other important matters about our protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. Such changes may apply to any of your protected health information that we maintain. If we change our privacy practices, we will revise the Notice of Privacy Practices and make the new Notice available upon request.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Privacy Officer listed at the end of the Notice of Privacy Practices. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SECTION C: PATIENTS OR REPRESENTATIVE SIGNATURE

I, _____, have received a copy of this office's Notice of Privacy Practices. I have had full opportunity to read and consider the contents of this Consent form and the Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information, or the protected health information of the patient I am representing**, to carry out treatment, payment activities, and health care operations.

Signature | Date

**If this Consent is signed by a representative on behalf of the patient, complete the following:

Patient's Name | Relationship to the Patient

SECTION D: REVOCATION OF CONSENT

******ONLYSIGN THIS SECTION IF YOU WISH TO REVOKE YOUR CONSENT******

I revoke my Consent for your use and disclosure of my protected health information, or that of the patient I am representing, for treatment, payment activities, and healthcare operations. I understand that revocation of my Consent will *not* affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me, or the patient I am representing, after I have revoked my Consent.

Signature | Date

HEALTH HISTORY
HISTORIA DE SALUD

CHART NO._____

PATIENT NAME (NOMBRE):_____ **DATE (FECHA):**_____

DATE OF BIRTH (FECHA DE NACIMIENTO):_____ **SEX (SEXO):** M / F **HEIGHT (ESTATURA):**_____ **WEIGHT (PESO LBS):**_____

Answer all questions and fill in blank spaces when indicated. Answers to the following questions are for our records only and will be strictly confidential.

	Yes	No
1. Are you in good health?	☐	☐
2. Has there been any significant change in your general health within the past year?	☐	☐
My last physical was on _____		
3. Are you now under the care of a physician?	☐	☐
If so, what is the condition being treated _____		
The name and telephone # of my physician is _____		
Please list any medications you are taking: _____		
4. Have you been hospitalized from a serious illness or operation within the last 5 years?	☐	☐
If so, explain _____		
5. Do you have or have you had any of the following diseases or problems:		
A. High or Low Blood Pressure?	☐	☐
B. Heart Conditions: Damaged/Artificial heart valves, Cardiovascular disease, murmurs, coronary insufficiency/occlusion, stroke, heart lesions or Mitral Valve Prolapse?	☐	☐
• Do you have pain in chest upon exertion?	☐	☐
• Are you ever short of breath after mild exercise?	☐	☐
• Do your ankles swell?	☐	☐
• Do you get short of breath when you lie down or do you require extra pillows when you sleep?	☐	☐
C. Do you have a cardiac pacemaker?	☐	☐
D. Do you have Rheumatic Fever/Heart Disease?	☐	☐
• Sinus trouble?	☐	☐
E. Asthma?	☐	☐
F. Hives or skin rash?	☐	☐
G. Fainting spells or seizures?	☐	☐
H. Diabetes?	☐	☐
• Do you have to urinate (pass water) more than 6 times a day?	☐	☐
• Are you thirsty much of the time?	☐	☐
I. Hepatitis, jaundice or liver disease?	☐	☐
J. Arthritis?	☐	☐
K. Inflammatory rheumatism? (Swollen joints)	☐	☐
L. Stomach ulcers?	☐	☐
M. Kidney trouble?	☐	☐
N. Tuberculosis?	☐	☐
O. Anemia?	☐	☐
P. A persistent cough or cough up blood?	☐	☐
• Do you have prosthetic hip or joint prosthesis, implants, bone plates or pins?	☐	☐
If so, what _____		
6. Have you had abnormal bleeding associated with previous extractions, surgery, or trauma?	☐	☐
• Do you bruise easily?	☐	☐
• Have you ever required a blood transfusion?	☐	☐
if so, explain _____		
7. Have you ever taken Phen-fen?	☐	☐
8. Do you drink Alcoholic Beverages?	☐	☐

Conteste todas las preguntas y Llene los espacios en blanco cuando se impliqué. Las contestaciones a nuestras preguntas son únicamente para nuestros archivos, y se consideran confidenciales.

	Sí	No
1. ¿Está usted en buena salud?	☐	☐
2. ¿Ha habido cambio de su salud durante el último año pasado?	☐	☐
Mi último examen médico fue en _____		
3. ¿Está ahora bajo atención médica?	☐	☐
Si es así, que enfermedad se está curando _____		
El nombre y # de teléfono de mi médico es _____		
Por favor detalle cualquier medicamentos que está tomando: _____		
4. ¿Ha estado hospitalizado de una enfermedad seria u operación dentro los últimos 5 años?	☐	☐
Si es así, explique _____		
5. ¿Tiene o ha tenido alguna de las siguientes enfermedades o problemas:		
A. ¿Alta o Baja presión arterial? (sangre)	☐	☐
B. ¿Enfermedad del Corazón: Válvulas artificiales o dañadas, insuficiencia cardiaca, oclusión coronaria, arteriosclerosis, sincope, Lesión cardiaca o Mitral Válvula Prolapso?	☐	☐
•¿Tiene dolor en el pecho cuando hace esfuerzo?	☐	☐
•¿Le falta el aire después de hacer algún ejercicio?	☐	☐
•¿Se le hinchan los tobillos?	☐	☐
•¿Cuándo se acuesta, le falta aire para respirar o le faltan más almohadas para dormir?	☐	☐
C. ¿Tiene un marcapasos cardiaco?	☐	☐
D. ¿Fiebre/Infección reumática del corazón?	☐	☐
•¿Problema de sinusitis?	☐	☐
E. ¿Asma?	☐	☐
F. ¿Ronchas o sarpullido?	☐	☐
G. ¿Desmayos y sudores o ataques?	☐	☐
H. ¿Diabitis?	☐	☐
•¿Orina usted más de seis veces por día?	☐	☐
•¿Tiene sed la mayoría del tiempo?	☐	☐
I. ¿Hepatitis, ictericia o enfermedad del hígado?	☐	☐
J. ¿Artritis?	☐	☐
K. ¿Inflamación reumática? (coyunturas inflamadas)	☐	☐
L. ¿Ulceras estomacales?	☐	☐
M. ¿Enfermedad del riñón?	☐	☐
N. ¿Tuberculosis?	☐	☐
O. ¿Anemia?	☐	☐
P. ¿Tos persistente o tos con sangre?	☐	☐
•¿Tiene cadera o conjuntara prostética, implantes, placa de hueso ir tornillos?	☐	☐
Si es así, que _____		
6. ¿Ha sangrado anormalmente, cuando una extracción dental, Cirugía o trauma?	☐	☐
• ¿Se moretea su piel fácilmente?	☐	☐
• ¿Ha requerido transfusión de sangre?	☐	☐
Sí es así, explique _____		
7. ¿Ha tomado usted Phen-fen?	☐	☐
8. ¿Usted toma tragos alcohólicos?	☐	☐

	Yes	No
9. Do you Smoke? ..... If so, how much _____	☐	☐
10. Have you had surgery or x-ray treatment for a tumor, growth or other condition of your mouth or lips?	☐	☐
11. Are you taking any of the following:		
A. Antibiotics or sulfa drugs?	☐	☐
B. Anticoagulants? (Blood thinners)..... If so, what _____	☐	☐
C. Medicine for high blood pressure?	☐	☐
D. Cortisone? (Steroids).....	☐	☐
E. Tranquilizers?	☐	☐
F. Antihistamine?	☐	☐
G. Insulin, tolbutamide (orinase) or similar drug?	☐	☐
H. Digitalis or drugs for heart trouble?	☐	☐
I. Nitroglycerin?	☐	☐
J. Oral contraceptive or other hormonal therapy?.....	☐	☐
K. Biphosphanates or any other bone cancer medications?	☐	☐
12. Are you allergic or have you reacted adversely to:		
A. Local anesthetics?	☐	☐
B. Penicillin or other antibiotics?	☐	☐
C. Barbiturates, sedatives or sleeping pills?	☐	☐
D. Aspirin or Sulfa Drugs?	☐	☐
E. Iodine?	☐	☐
F. Codeine or other narcotics?	☐	☐
G. Latex or rubber products?	☐	☐
H. Other _____		
13. Have you had any problems or serious trouble associated with any previous dental treatment? ..... If so, explain _____	☐	☐
14. Are you employed in any situation which exposes you regularly to x-rays or other ionizing radiation?	☐	☐
15. Do you have, or have you had personal contact with anyone who has the following? (please circle)		
☐ A. Herpes ☐ B. Hepatitis		
☐ C. TB ☐ D. AIDS		
☐ E. Venereal Disease ☐ F. HIV		
16. Are you pregnant or think you might be?	☐	☐
17. Are you nursing?	☐	☐
18. Do you have any other medical, mental or physical problem/condition not listed above? (Autism, Down's Syndrome, etc.) ..... If so, explain_____	☐	☐

	Sí	No
9. ¿Usted Fuma? ..... Si es cierto, cuanto _____	☐	☐
10. ¿Ha tenido cirugía o rayos x para tratar algún tumor, creco, u otra enfermedad de la boca o labios?	☐	☐
11. Está tomando los siguientes medicamentos:		
A. ¿Sulfamidas o antibióticos?.....	☐	☐
B. ¿Anticoagulantes? (aclarar la sangre)..... Sí es así, que _____	☐	☐
C. ¿Medicamento contra la alta presión?.....	☐	☐
D. ¿Cortisona? (esteroide).....	☐	☐
E. ¿Tranquilizantes?.....	☐	☐
F. ¿Antihistaminico?.....	☐	☐
G. ¿Insulina, tobultamida o drogas similares?.....	☐	☐
H. ¿Para enfermedades del corazón?.....	☐	☐
I. ¿Nitroglicerina?.....	☐	☐
J. ¿Anticonceptivos orales u otra terapia hormonal?	☐	☐
K. ¿Biphosphanates o cuaesquiera otras medicaciones del cáncer de hueso?	☐	☐
12. ¿Esta alérgico o ha reaccionado adversamente a:		
A. ¿Anestesia local?.....	☐	☐
B. ¿Antibióticos o penicilina?.....	☐	☐
C. ¿Barbitúrico, sedantes o pastillas para dormir?.....	☐	☐
D. ¿Aspirina ir Drogas con solfas?.....	☐	☐
E. ¿Yodo?.....	☐	☐
F. ¿Codeína u otros narcóticos?.....	☐	☐
G. ¿Látex o productos de hule?.....	☐	☐
H. Alguna otra _____		
13. ¿Ha tenido algún problema después de haber tenido un tratamiento dental? ..... Si es así explique _____	☐	☐
14. ¿Está trabajando o está en una situación donde está expuesto regularmente a radiografías o alguna otra forma de radiación?	☐	☐
15. ¿Usted tiene o ha estado en contacto personal con alguien con lo siguiente? (por favor de circular)		
☐ A. Herpes ☐ B. Hepatitis		
☐ C. Tuberculosis ☐ D. SIDA		
☐ E. Enfermedades Venéreas ☐ F. HVI		
16. ¿Está usted embarazada o piensa que si?	☐	☐
17. ¿Está amamantando (dando pecho)?	☐	☐
18. ¿Tiene usted alguna otra enfermedad o condición no mencionada anteriormente? (Autismo, Síndrome de Down, etc.) ..... Si es así, explique_____	☐	☐

I have filled out this Health Questionnaire completely. I have advised you of all medical problems of which I am aware. I further certify that I, the undersigned, consent to the performing of x-rays, examination and whatever dental treatment may be agreed upon to be necessary or advisable.

Yo he leído lo de arriba y he contestado este cuestionario de Salud totalmente. He dado a conocer todos los trastornos de que conocimiento. Además certifico que yo, el que firma, presto mi consentimiento para que hagan el uso de rayos X, reexaminación o cualquier tratamiento dental que sea de acuerdo o aconsejado.

_____ _____
SIGNATURE OF PATIENT OR LEGAL GUARDIAN — DATE

_____ _____
FIRMA DEL PACIENTE — FECHA

Medical Clearance required: ____Yes ____No

_____ _____
SIGNATURE OF DOCTOR (Firma del Doctor) — DATE

For: _____

Update to medical history/Actualizar* Historia de salud --- *Update to noting no change in Medical History. Actualizar es notar ningun cambio en la Historia De Salud.

DATE/FECHA	COMMENTS/COMENTARIOS	PATIENT SIGNATURE/FIRMA DEL PACIENTE	DR. SIGNATURE