SMILE CENTER LOS ALGODONES
SIGRID LÓPEZ DDS.
PROFESSIONAL LICENCE 5701748
AV. B CORNER 3RD ST #203, LOS ALGODONES, B.C MÉXICO.

DATE_____/_____/_____

CLINIC MEDICAL HISTORY

Name: _____ Date of Birth: _____/_____/_____
Last First M.I

Home Address: _____ City: _____ State: _____

Home Phone: _____ Cell Phone: _____ Sex: M ◯ F ◯

How did you find us? _____ Reason for appointment? _____

When was your last dental exam? _____ Emergency contact:
Name & Phone: _____

Email: _____

AS REQUIRED BY LAW, OUR OFFICE ADHERES TO WRITTEN POLICIES AND PROCEDURES TO PROTECT THE PRIVACY OF INFORMATION ABOUT YOU THAT WE CREATE, RECEIVE OR MAINTAIN. YOUR ANSWERS ARE FOR OUR RECORDS ONLY AND WILL BE KEPT CONFIDENTIAL SUBJECT TO APPLICABLE LAWS. PLEASE NOTE THAT YOU WILL BE ASKED SOME QUESTIONS ABOUT YOUR RESPONSES TO THIS QUESTIONNARIE AND THERE MAY BE ADDITIONAL QUESTIONS CONCERNING YOUR HEALTH. THIS INFORMATION IS VITAL TO ALLOW US TO PROVIDE APPROPIATE DENTAL CARE FOR YOU. THIS OFFICE DOES NOT USE THIS INFORMATION TO DISCRIMINATE.

- •Are you in good health? YES___NO___
- •Are you under any medical treatment? YES___NO___
- •Do you take cortisone, blood thinners, aspirin or Coumadin? YES___NO___
- •Have you been hospitalized or had a serious illness within the past 5 years? YES___NO___
- •Are you pregnant? YES___NO___
- •Do you smoke or have or have problems with alcoholism? YES___NO___

- •High blood pressure YES ___NO___
- •Heart attack YES ___NO___
- •Heart disease YES ___NO___
- •Do you use a pacemaker YES ___NO___
- •Stroke or mini stroke YES ___ NO___
- •Tuberculosis YES ___ NO___
- •AIDS/HIV Positive YES ___NO___
- •ADD/ADHD YES ___NO___
- •Diabetes YES ___NO___
- •Low blood pressure YES ___NO___
- •Osteoporosis YES ___NO___
- •Asthma YES ___NO___

List all medications you are now taking (please include over the counter vitamins, herbs, pain relievers, and drugs: _____

Are You Allergic To Any Medication? Please explain:
_____

Any Other Medical Conditions Not Listed Above?: _____

_____
Dentist Signature

_____
Patient Signature

EXP NO._____

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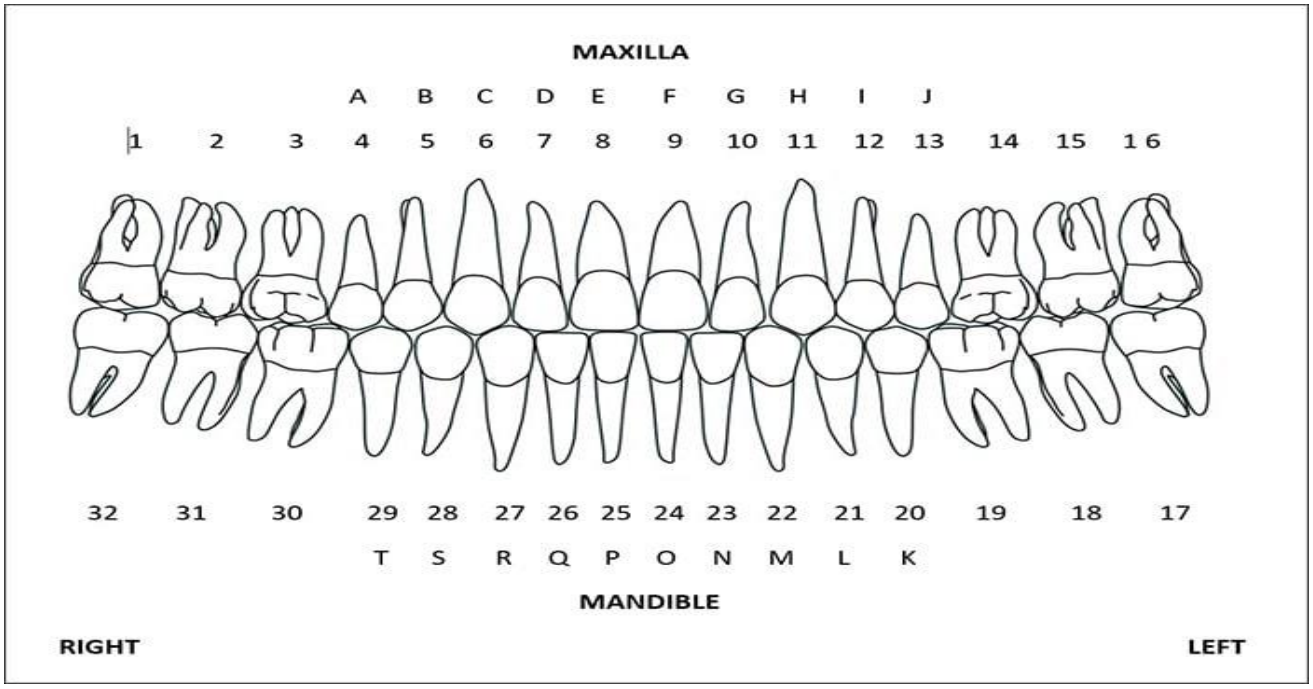
HISTORIA CLÍNICA



FECHA	OBSERVACION O TRATAMIENTO	DOCTOR

EXP NO._____

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Name:_____ Sex: M ◯ F ◯ Age:_____

You the patient have the right to accept or reject dental treatment recommended by your dentist. Prior to consenting to treatment, you should carefully consider the anticipated benefits and commonly known risks of the recommended procedure, alternative treatments, or the option of no treatment. Please do not consent to treatment unless and until you discuss potential benefits, risks, and complications with your dentist and all of your questions are answered. By consenting to treatment, you acknowledge your willingness to accept known risks and complications, no matter how slight the probability of occurrence.

1. EXAMINATION AND X-RAYS

I understand that the initial visit may require radiographs in order to complete the examination, diagnosis, and treatment plan.

2. DRUGS, MEDICATION, AND SEDATION

I have been informed and understand that antibiotic, analgesics, and other medications can cause allergic reactions causing redness, swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). They may cause drowsiness and a lack of awareness and coordination, which can be increased by the use of alcohol or other drugs

3. CHANGES IN TREATMENT PLAN

I understand that during treatment, it may be necessary to change or add procedures because found while working on teeth that were not discovered during the initial examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the Dentist to make any or all changes and additions as necessary.

4. TEMPOROMANDIBULAR JOINT DYSFUNCTIONS (TMJ)

I understand that symptoms of popping, clicking, locking and pain can intensify or develop in the joint of the lower (near the ear) subsequent to routine dental treatment wherein the mouth is held in the open position.

I, _____, HAVE REVIEWED THE INFORMATION ON THIS MEDICAL HISTORY FORM AND IT IS ACCURATE TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT THE DOCTOR TO HELP DETERMINE APPROPRIATE AND HEALTHFUL TREATMENT WILL USE THIS INFORMATION. IF THERE IS ANY CHANGE IN MY MEDICAL STATUS, I WILL INFORM THE DOCTOR. I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE.

_____ _____

Dentist Signature Patient Signature

EXP NO._____