

MEDICAL BACKGROUND INFORMATION  
HISTORIA MEDICA

Mr. Ms. Mrs. Name (Nombre) \_\_\_\_\_ Date of Birth(Fecha de Nacimiento) \_\_\_\_\_  
Circle one (Escoja Una) Last(apellido) First(Primer Nombre) MMDDYYYY

Sex (Sexo) M F Last dental visit(Ultima visita al dentista) \_\_\_\_\_ Same Insurance? YES  NO   
¿El Mismo seguro?

Address (Direccion) \_\_\_\_\_ Apt. \_\_\_\_\_  
City (Ciudad) State (Estado) Zip code (Código Postal)

Telephone (Telefono) \_\_\_\_\_ Home(casa) \_\_\_\_\_ Mobile(celular) \_\_\_\_\_ Work(trabajo) \_\_\_\_\_

Social Security Number (Numero Seguro Social) \_\_\_\_\_

E-MAIL ADDRESS \_\_\_\_\_

How did you hear about us (¿Cómo usted oyó hablar de nosotros?) \_\_\_\_\_

Purpose of this visit (El proposito de esta visita) \_\_\_\_\_

Payment (pago)  Insurance(seguro)  Cash/Credit Card(Dinero Efectivo /Tarjeta de credito)  
 Medicaid (Medicaid)  Other (Otro)

\*How do you feel about the Appearance of your teeth? \_\_\_\_\_

\*If you could change your smile, how would you change it? \_\_\_\_\_

\*Do you have bad breath? \_\_\_\_\_

1. Are you taking any medication at this time?..... YES  NO   
¿Esta tomando usted actualmente algun medicamento?
2. Have you ever been treated for any heart condition, high blood pressure or any..... YES  NO   
prolonged illness such as diabetes, asthma, kidney disease, HIV+, etc  
¿Ha sido usted tratado de alguna condicion del Corazon, presion alta o cualquier enfermedad prolongada como diabetes, asma o riñon, o HIV?
3. Have you ever had prolonged bleeding from injury, tooth extraction, etc..... YES  NO   
¿Ha tenido usted algun sangramiento prolongado debido a una herida, o extraccion de una pieza dental?
4. Have you ever had heart murmur or rheumatic fever?..... YES  NO   
¿Ha tenido usted murmullo del Corazon o fiebre rheumatica?
5. Are you allergic to any drugs, foods, materials or pollens?..... YES  NO   
¿Es usted alergico a algun medicamento, alimento o los polenes?
6. Have you ever had a reaction from any anesthetics?..... YES  NO   
¿Es alergico a la anesthesia?
7. Are you presently or have you, during the past two years, been under care of physician?..... YES  NO   
¿En la actualidad, o durante los ultimos 2 años estuvo bajo cuidado medico?
8. Do you have or have you recently had any evidence of infections, such a boils, infected wounds, severe sore throat or persistent cough?..... YES  NO   
¿Tiene o ha tenido recientemente infeccion, heridas infectadas, severo dolor de garganta o tos persistente?
9. Have you ever had any illness or complication following dental treatment of any kind?..... YES  NO   
¿Ha tenido alguna enfermedad o complicacion a tratamiento dental de cualquier condicion?
10. Have you ever had any other illness or condition other than common cold, virus or flu?..... YES  NO   
¿Aparte de virus, gripa, alergia, ha sufrido o sufre de alguna enfermedad?
11. Do you have reason to believe that you are not presently in good health?..... YES  NO   
¿Tiene usted razon para pensar que no tiene en la actualidad una Buena salud?
12. If you are a woman, are you pregnant?..... YES  NO   
¿Esta usted embarazada?

By signing below I accept that: I fully understand what is being asked and if there are any changes in status of any of the afore asked questions, I am responsible in alerting my treating dentist of the changes.

Signature(Firma) \_\_\_\_\_

Date(Fecha) \_\_\_\_\_