Patient Information
Informacion del Paciente

Chart # _____

Date _____ **Patient's Name** _____
Fecha Nombre Last / Apellido First / Nombre Middle / 2do Nombre

Address _____
Domicilio del paciente Street / Calle Apt # City / Ciudad ZIP Code / Zona Postal

Cell Phone:( ) _____ **E-mail:** _____
Telefono Movil

Home Phone:( ) _____ **Work:( )** _____ **Employer Name & Address:** _____
Telefono Numero de Trabajo Domicilio del Trabajo

Birthday ___/___/___ **Age** _____ ❑ **Married**-Casado (A) ❑ **Divorced**-Divorciado (A) **Occupation:** _____
Fecha de nacimiento Edad ❑ **Single**-Soltero (A) ❑ **Widowed**-Viudo (A) Profesion

Social Security Number: _____ **Driver's License Number:** _____
Seguro Social Numero de Licencia de Manejar

Responsible Party and Insurance Information
Persona Responsable de Cuentay Informacion de su Aseguranza

If patient is a minor, give parents / guardian's

Name / Nombre: _____ **Phone / Telefono:** _____

In the event of an emergency please contacts:

Name: _____ **Relationship:** _____ **Phone:** _____

Name: _____ **Relationship:** _____ **Phone:** _____

Please Check your payment option. ❑ **Insurance** ❑ **or Self Pay / Cash** ❑ **Care credit**
Indique opcion de pago. **Aseguranza** **Pagando**

INSURANCE INFORMATION:
Informacion de Aseguranza:

Name of Insurance: _____ **Group Number:** _____
Nombre de Aseguranza: Numero de Su Grupo:

Name of Subscriber: _____
Nombre del Asegurado (A):

ID# or
Social Security of Subscriber: _____ **Date of Birth:** _____
Seguro Social del Asegurado (A): Fecha de Nacimiento:

Driver's License Number: _____ **Name of Employer:** _____
Numero de Licencia:- Nombre de Compania:

Employer's Address: _____
Domicilio del Trabajo: City / Ciudad State / Estado Zip / Zona Postal

How did you hear about our Office? (check only one)

Who selected this Office? ❑ Self ❑ Spouse ❑ Parent ❑ Employer

Where did you find the Phone Number to this Office? _____

❑ Referred by a friend ❑ Yelp ❑ Relative ❑ Insurance Plan ❑ Sign by Building

❑ Google ❑ Website ❑ Direct Mailing ❑ Other _____

If you were referred, whom may we thank for referring you? _____

Dr. Kenneth Cho
DENTISTRY

Medical Information
Informacion Medical

PLEASE CIRCLE YES OR NO

1. **Are you having pain or discomfort at this time?** YES NO / SI NO
   Tiene dolor o molesita en este momento?
2. **Have you been hospitalized during the past two years?** YES NO / SI NO
   Ha estado hospitalizado en los ultimos dos anos?
3. **Are you taking any medication or drugs?** YES NO / SI NO
   Esta tomando algun medicamento o drogas?
4. **Are you sensitive or Allergic to any medications or Anesthetic?** YES NO / SI NO
   Tiene Alergia a un medicamento o Anestecia?
5. **Do your gums bleed when you brush?** YES NO / SI NO
   Su encilla sangra al cepillarse?
6. **Are your teeth sensitive to hot or cold?** YES NO / SI NO
   Son sensitivos sus dientes a lo caliente o frio?
7. **Do you grind your teeth?** YES NO / SI NO
   Rechina sus dientes?
8. **Do you have any fear of Dental work?** YES NO / SI NO
   Tiene temor a trabajo dental?
9. **Last Dental Visit?** _____
   Fecha de ultima visita dental?
10. **Reason why you left previous dentist?** _____
    Razon que cambio de dentista?

HEALTH HISTORY
HISTORIA DE SALUD

Physician's Name: _____ **Date of last visit:** _____
Nombre de su doctor: Fecha de ultima vista:

Place a mark on "Yes" or "No" to indicate if you had any of the following:
Indique si padece de lo siguiente:

AIDS SIDA	❑Yes ❑No	**Epilepsy** Epilepsia	❑Yes ❑No	**Psychiatric Care** Cuidado Psiquiatrico	❑Yes ❑No
Anemia Anemia	❑Yes ❑No	**Fainting or Dizziness** Desmayos o mareos	❑Yes ❑No	**Radiation Treatment** Tratamiento radial	❑Yes ❑No
Arthritis, Rheumatism Artritis	❑Yes ❑No	**Glaucoma** Glaucoma	❑Yes ❑No	**Respiratory Disease** Enfermedad con la respiracion	❑Yes ❑No
Artificial Heart Valve Valvula artificial del Corazon	❑Yes ❑No	**Headaches** Dolores de cabeza	❑Yes ❑No	**Rheumatic Fever** Rheumatic Fever	❑Yes ❑No
Artificial Joints Articulacion Artificial	❑Yes ❑No	**Heart Murmur** Soplo en el Corazon	❑Yes ❑No	**Scarlet Fever** Scarlet Fever	❑Yes ❑No
Asthma Asma	❑Yes ❑No	**Heart Problems** Problemas del Corazon	❑Yes ❑No	**Shortness of Breath** Respiracion corta	❑Yes ❑No
Back Problems Problemas de Espalda	❑Yes ❑No	**Hepatitis (Type)** Hepatitis (Tipo)	❑Yes ❑No	**Sinus Trouble** Problemas de sinusitis	❑Yes ❑No
Bleeding abnomally, with extractions or surgery Sangramiento abnormal en cirugias o extracciones	❑Yes ❑No	**Herpes** Herpes	❑Yes ❑No	**Skin Rash** Sarpullido	❑Yes ❑No
Blood Disease Enfermedad de la sangre	❑Yes ❑No	**High Blood Pressure** Alta presion	❑Yes ❑No	**Special Diet** Dieta especial	❑Yes ❑No
Cancer Cancer	❑Yes ❑No	**HIV Positive** HIV positiva	❑Yes ❑No	**Stroke** Derrame	❑Yes ❑No
Chemical Dependency Dependencia quimica	❑Yes ❑No	**Jaundice** Ictericia	❑Yes ❑No	**Swelling of Feet or Ankles** Inchazon de pie o tobillo	❑Yes ❑No
Chemotherapy Quimoterapia	❑Yes ❑No	**Jaw Pain** Dolor de quijada	❑Yes ❑No	**Thyroid Problems** Problemas de tiroides	❑Yes ❑No
Circulatory Problems Problemas de circulacion	❑Yes ❑No	**Kidney Disease** Enfermedad del rinon	❑Yes ❑No	**Tonsillitis** Amigdalitis	❑Yes ❑No
Congenital Heart Lesions Lesion congenital del Corazon	❑Yes ❑No	**Liver Disease** Enfermedad del higado	❑Yes ❑No	**Tuberculosis** Tuberculosis	❑Yes ❑No
Cortisone Treatments Tratamientos de cortisona	❑Yes ❑No	**Low Blood Pressure** Baja presion	❑Yes ❑No	**Tumor or growth on head or neck** Tumor en la cabeza o cuello	❑Yes ❑No
Cough, persistent or bloody Tos persistente o con sangre	❑Yes ❑No	**Mitral Valve Prolapse** Mital Valve Prolapse	❑Yes ❑No	**Ulcer** Ulcera	❑Yes ❑No
Diabetes Diabetis	❑Yes ❑No	**Nervous Problems** Problema nervioso	❑Yes ❑No	**Venereal Disease** Enfermedad Veneria	❑Yes ❑No
Emphysema Emphysema	❑Yes ❑No	**Pacemaker** Marcapso	❑Yes ❑No	**Weight Loss, Unexplained** Perdida de peso sin razon	❑Yes ❑No
Do you wear contact lenses? Usa lentes de contacto?	❑Yes ❑No	**Women: Are you pregnant?** Mujeres: Esta ud. Embarazada?	❑Yes ❑No		
		Due Date _____ Fecha de parto			
		Are you nursing? Esta ud. Amamantando?	❑Yes ❑No		

MEDICATIONS

List medications you are currently taking? _____
Medicamentos que esta tomando en este momento?

_____

Have you ever taken Fen Phan? ❑ **Yes** ❑ **No**
Ha tomado Fen Phan?

Have you ever taken Redux? ❑ **Yes** ❑ **No**
Ha tomado Redux?

When were your last dental x-rays? _____
Usa lentes de rayos-x dentales?

ALLERGIES

❑ **Aspirin** - Aspirina
❑ **Barbituates (sleeping pills)**
❑ **Codeine**
❑ **Lodine**
❑ **Latex**
❑ **Local Anesthetic** - Anestecia Local
❑ **Penicillin** - APenicilina
❑ **Sulfa**
❑ **Other** _____

P/BP	DOCTOR'S SIGNATURE

CONSENT:
The undersigned hereby authorized the doctor to order x-rays, study models, photos or any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of the patient's dental needs. I also understand that all responsibility for payment(s) for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless other arrangements have been made. Failure to pay may result in reporting to local credit bureau and collection agency in effort to satisfy the balance. I also understand that it is my responsibility to report any changes and information indicated on this form. I also am aware & understand that having dental insurance is not a guarantee of payment. I understand that the above information is necessary to provide me and members of my family being treated with safe and adequate dental care in an efficient manner. I have answered all questions truthfully and to the best of my knowledge.

Patient's signature _____ Date _____