# REGISTRO DEL PACIENTE E HISTORIA CLÍNICA

Fecha_____ (POR FAVOR, ESCRIBA EN LETRA DE IMPRENTA) Teléfono Particular (_____)_____

Paciente_____
Apellido Primer Nombre Inicial Nombre Preferido

Dirección – Calle_____ Ciudad_____ Estado_____ Código Postal_____

Dirección de Correo Electrónico_____

Sexo: ☐ M ☐ F Edad_____ Fecha de Nacimiento_____ ☐ Soltero(a) ☐ Casado(a) ☐ Viudo(a) ☐ Separado(a) ☐ Divorciado(a)

Empleado(a) por_____ Ocupación_____

Dirección del Empleador_____ Teléfono del Empleador (_____)_____

Nombre del Cónyuge/Padre o Madre_____ Fecha de Nacimiento del Cónyuge/Padre o Madre_____

Cónyuge/Padre o Madre Empleado por_____ Ocupación_____

Dirección del Empleador_____ Teléfono del Empleador (_____)_____

¿Quién es responsable por esta cuenta?_____ Relación con el Paciente_____

No. de Seguro Social_____ No. de Seguro Social del Cónyuge/Padre o Madre_____

Nombre de la Compañía del Seguro Dental_____ Grupo Número_____

En caso de emergencia, ¿a quién se deberá notificar?_____ Teléfono (_____)_____

¿A quién podemos agradecer por habernos referido a Ud.?_____

## HISTORIA CLÍNICA

Nombre del Médico_____ Fecha del Último Examen Físico_____

¿Ha tenido Ud. alguna vez algo de lo siguiente? (marque las casillas que correspondan):

| SI | NO | | SI | NO | | SI | NO | |
|---|---|---|---|---|---|---|---|---|
| ☐ | ☐ | Problemas del Corazón | ☐ | ☐ | Epilepsia | ☐ | ☐ | Dieta Especial |
| ☐ | ☐ | Presión Sanguínea Alta | ☐ | ☐ | Dolores de Cabeza | ☐ | ☐ | Glándulas del Cuello Hinchadas |
| ☐ | ☐ | Presión Sanguínea Baja | ☐ | ☐ | Hepatitis, Ictericia o Enfermedad del Hígado | ☐ | ☐ | Fiebre Reumática |
| ☐ | ☐ | Problemas Circulatorios | ☐ | ☐ | Cáncer | ☐ | ☐ | Problemas de la Sinus |
| ☐ | ☐ | Problemas Nerviosos | ☐ | ☐ | Tratamiento Siquiátrico | ☐ | ☐ | VIH/SIDA u Otros Trastornos Inmunosupresores |
| ☐ | ☐ | Radioterapia | ☐ | ☐ | Diarrea Crónica | | | |
| ☐ | ☐ | Articulaciones o Válvulas del Corazón Artificiale | ☐ | ☐ | Alergias a Anestesias | ☐ | ☐ | Embolia Cerebral |
| ☐ | ☐ | Reciente Pérdida de Peso | ☐ | ☐ | Alergias a Medicinas o Drogas | ☐ | ☐ | Úlcera |
| ☐ | ☐ | Problemas de la Espalda | ☐ | ☐ | Alergias Generales | ☐ | ☐ | Enfermedades Venéreas |
| ☐ | ☐ | Diabetes | ☐ | ☐ | Enfermedad de la Sangre | ☐ | ☐ | Drogaadicción |
| ☐ | ☐ | Enfermedades Respiratorias | ☐ | ☐ | Artritis | ☐ | ☐ | Hemofilia |

¿Tiene Ud. alguna alergia a medicamentos, o ha tenido Ud. alguna vez una reacción adversa a algún medicamento?_____

Si la respuesta es afirmativa, ¿a qué?_____

¿Ha reaccionado Ud. alguna vez adversamente a un tratamiento médico o dental?_____

¿Está tomando Ud. actualmente algún medicamento?_____ Si la respuesta es afirmativa, ¿cuál?_____

¿Ha tomado Ud. alguna vez algún medicamento del grupo al que se le conoce como "fenfen" (fenphen, en inglés). Esto incluye combinaciones de Ionimin, Adipex, Fastin (nombres de marcas de fentermina), Pondimin (fenfluramina) y Redux (dexfenfluramina). ☐ Sí ☐ No

¿Está Ud. bajo el cuidado de un médico? ☐ Sí ☐ No ¿Por el tratamiento de qué condiciones? _____

Si el paciente es un niño, ¿cuánto pesa el niño?_____

(Mujeres) ¿Sospecha Ud. que está embarazada? ☐ Sí ☐ No ¿Está Ud. amamantando a un bebé? ☐ Sí ☐ No

¿Hay alguna otra cosa que nosotros debiéramos saber sobre su historia clínica?_____

La información de arriba es correcta y completa, a mi leal saber y entender, y se proporciona con el único objeto de que se use en mi tratamiento, para facturación y para procesamiento ante el seguro de los beneficios a los que tengo derecho. Yo no haré responsable a mi dentista ni a ningún integrante de su personal por errores u omisiones que yo pueda haber cometido al llenar este formulario.

Fecha_____ Firma_____

(SIGUE AL DORSO)

# DENTAL TREATMENT CONSENT FORM

**DENTIST'S NAME: Dr Lilia Larin** **PATIENT'S NAME:**

Please read and initial the items checked below and read and sign at the bottom of form.

**1. X-RAYS** (Initials_____)

**2. DRUGS AND MEDICATIONS**

I understand that antibiotics and analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain itching, vomiting, and/or anaphylactic shock (severe allergic reaction). (Initials_____)

**3. CHANGES IN TREATMENT PLAN**

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

**4. REMOVAL OF TEETH**

Alternatives to removal have been explained to me (root canal therapy, crowns, and periodontal surgery, etc.) and I authorize the Dentist to remove the following teeth and any others necessary for reasons in paragraph #3. I understand removing teeth does not always remove all the infection, if present, it may be necessary to have further treatment. I understand the risks involved in having teeth removed, some of which are pain, swelling, spread of infection, dry socket, loss of feeling in my teeth, lips, tongue and surrounding tissue(Paresthesia) that can last for an indefinite period of time(days or months) or fractured jaw. I understand I may need further treatment by a specialist or even hospitalization. If complications arise during or following treatment, the cost of which is my responsibility. (Initials_____)

**5. CROWNS, BRIDGES AND CAPS**

I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realize the final opportunity to make changes in my new crown, bridge, or cap (including shape, fit , size, and color) will be before cementation. (Initials_____)

**6. DENTURES, COMPLETE OR PARTIAL**

I realize that full or partial dentures are artificial, constructed of plastic, metal, and/or porcelain. The problems of wearing these appliances have been explained to me, including looseness, soreness, and possible breakage. I realize the final opportunity to make changes in my new dentures ( including shape, fit, size placement and color) will be the "teeth in wax" try-in visit. I understand that most dentures require relining approximately three to twelve months after initial placement. The cost for this procedure is not included in the initial denture fee. (Initials_____)

**7. ENDODONTIC TREATMENT (ROOT CANAL)**

I realize there is no guarantee that root canal treatment will save my tooth, and that complications can occur from the treatment, and that occasionally metal objects are cemented in the tooth or extend through the root, which does not necessarily affect the success of the treatment, I understand that occasionally additional surgical procedures may be necessary following root canal treatment (apicoectomy). (Initials_____)

**8. PERIODONTAL LOSS (TISSUE & BONE)**

I understand that I have a serious condition, causing gum and bone inflammation or loss and that it can lead to the loss of my teeth. Alternative treatment plans have been explained to me, including gum surgery, replacement and/or extractions. I understand that undertaking any dental procedures may have a future adverse effect on my periodontal condition. (Initials_____)

**9. FILLINGS**

*I understand that care must be exercised in chewing on fillings* especially during the first 24 hours to avoid breakage. I understand that a more expensive filling that initially diagnosed may be required due to additional decay. I understand that significant sensitivity is a common after effect of a newly placed filling. (Initials_____)

**10. DENTURES**

I understand the wearing of dentures is difficult. Sore spots altered speech and difficultly in eating are common problems. Immediate dentures (placement of dentures immediately after extractions) may be painful. Immediate dentures may require considerable adjusting and several relines. A permanent reline will be needed later. This is not included into the denture fee. I understand that it is my responsibility to return for delivery of the dentures. I understand that failure to keep my delivery appointment may result in poorly fixed dentures. If a remake is required due to my delays of more that 30 days there will be additional charges. (Initials_____)

I understand that dentistry is not an exact science and that, therefore, reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been make by anyone regarding the dental treatment which I have requested and authorized. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction. I consent to the proposed treatment.

**Signature of Patient**_____ **Date**_____

**Signature of Parent/Guardian if patient is a minor**_____ **Date**_____

**CONSENT 2**

South Coast Dental
Dr Lilia Larin, DDS
617-477-1970 (Ph)
617-477-6117 (Fax

**South Coast Dental**

## Cancellation Policy

We apologize for any inconvenience this notice may cause but in order to help standardize our appointment schedule and to help open up valuable time for fellow patients we require a 48 hour cancellation notice. If we do not receive a 48 hour cancellation notice you will be charged $35.00.

For specialist services the cancellation fee is $150.00.

Thanks for your cooperation.

_____

Signature

## Poliza de Cancelacion

Perdone por cualquier inconveniencia que pueda causar este poliza pero para mantener un horario solido y beneficio para nuestros pacientes estamos pidiendo que porfavor si por cualquier motivo necesita cambiar o cancelar alguna de sus citas nos de un aviso previo con un minimo de 48 horas antes de la hora de su cita . Si no atiende a su cita o no cancela con un minimo de 48 horas antes sera necesario cobrarle $35.00 por la falta.

Servicios de especialista cancelados o fallados se cobran a $150.00 dlls.

Gracias por su cooperacion.

_____

Signature

South Coast Dental

# ASSIGNMENT OF DENTAL INSURANCE BENEFITS

Welcome to our office! We are committed to providing you with the best possible dental care with kindness and professionalism. We are happy to work with you by submitting your insurance claims with participating insurance carriers but would like you understand our office policy regarding insurance assignment.

Please bear mind that your dental insurance is a contract between you, your employer and the insurance carrier. Generally, our fees fall within the range most insurance companies accept and are therefore covered up to maximum allowance allowed negotiated with each insurance company. However, not all services are covered benefits in every contract.

You acknowledge that it is your responsivity to:

1. Provide complete up-to date information on dental insurance coverage for the patient. This includes information on all plans, if enrolled in more then one plan.
2. Present a valid insurance card at each visit.
3. Pay your portion for services not covered at 100% (see above) at each visit.
4. Pay within 30 days any balance on your account for any amounts for any due this office such as deductibles, co-payment, non-covered services.
5. You are ultimately responsible to pay the dental bill if the assignment of benefits is not honored in whole or in part.

Your signature below indicates:

1. You understand and accept our policy of assignment of insurance benefits.
2. You attest to the accuracy and completeness of the dental insurance coverage information,
3. You authorize this office to release this office to release the information necessary to process your claims and appeals. .
4. You authorize payment of dental benefits to South Coast Dental.

_____

Signature of Patient or Responsible Party Date

**Patient information:**

Patient's Name _____Date of Birth _____

**Subscribers Information:**

Subscribers Name _____Date of Birth _____

Subscriber ID #_____

Group _____Employers Name _____

(NOMBRE DEI CONSULTORIO)

# CONFIRMACIÓN DE RECIBO DEL AVISO DE LAS PRÁCTICAS DE PRIVACIDAD

*Usted Puede Rehusarse a Firmar Esta Confimación*

Yo, _____, he recibido una copia del Aviso de las Prácticas de Privacidad de este consultorio.

_____
Nombre en letra de imprenta

_____
Firma

_____
Fecha

**Para uso del consultorio solamente**

Intentamos obtener confirmación por escrito del recibo do nuestro Aviso de las Prácticas de Privacidad, poro no se pudo obtener la confirmación porque:

- ☐ El individuo rehusó firmar
- ☐ Barreras en la comunicación prohibieron obtener la confirmación
- ☐ Una situación de emergencia nos impidió obtener la confirmación
- ☐ Otras (Especifique por favor)_____



(Este Formulario es exclusivamente educativo, no constituye asesoramiento legal, y cubre solamente la ley federal, no la estatal, que esté en vigor o propuesta el 27 de marzo de 2002. Cambios subsiguientes a la ley pueden requerir la revisión del Formulario.)