PATIENT INFORMATION FOR ADULTS
(INFORMACION DEL PACIENTE PARA ADULTOS)

Date (Fecha):_____

Name(Nombre):_____

Nickname (Apodo):_____ Gender (Sexo):_____Male _____Female

Birthdate (Fecha de nacimiento):_____

StreetAddress(Direccion):_____

City/County(Ciudad)_____ State(Estado):_____ Zipcode(Código Postal):___

Phone#(# de Telefono):_____ Other Number(Otro Numero):_____

Email(Correo Electronico):_____Social Security:_____

Occupation/Ocupacion):_____

Name of person to contact in case of an emergency(En caso de emergencia, a quien se deberá notificar?):

_____

Dental Insurance Information (Información del Seguro Dental)

Primary Insured's Name(Nombre del asegurado):_____

Insured's Social Security #(# de social security del asegurado):_____

Insured's Birthday (Fecha de Nacimiento del asegurado):_____

Insurance Company(Compañía del Seguro Dental):_____

Group#(Numero de Grupo):_____Member ID #(Numeró de Póliza):_____

Insurance Phone#(Teléfono del Seguro):_____

Relationship to patient(Relacion al paciente):_____

Employer(Empleador):_____

6066 Leesburg Pike Suite 101 Falls Church, VA 22041 TEL:(571)371-8171 FAX:(571)371-8070

Dental History(Historia Dental)

Name of your previous dentist(Nombre del dentista anterior):_____

Phone Number(Numero de telefono):_____

Last visit to the dentist(Fecha de última visita al dentista):_____

How many times do you brush your teeth daily(Cuantas veces se cepilla los dientes diario):___

How often do you floss(Frequencia de uso de hillo dental):_____

Do you have or have you ever had any of the following:

Bleeding, sore gums? **Yes / No**
Unpleasant taste/bad breath? **Yes / No**
Swelling/lumps in mouth? **Yes / No**
Orthodontic treatment (braces?)**Yes / No**
Clenching/grinding? **Yes / No**
Sensitive to sweets? **Yes / No**
Sensitive to biting? **Yes / No**
Food Impaction? **Yes / No**
Biting cheeks/lips? **Yes / No**
Shifting in bite? **Yes / No**
Change in bite? **Yes / No**
Burning tongue/lips? **Yes / No**
Frequent blister, lips/mouth? **Yes / No**
Sensitive teeth (hot or cold?) **Yes /No**
Clicking/popping jaw? **Yes / No**
Difficulty opening or closing jaw? **Yes / No**
Loose teeth? **Yes / No**

Medical History(Historia Clinica)

Please mark the following that applies to your child(Por favor marque lo que aplica a su usted):

OAIDS/HIV Positive
OAlzheimer's Disease
OAnemia-Chronic
OAntipsychotic Medications
OArtificial Heart Valve
OAutismq Cancer Type? _____
OChemical Dependency/Alcohol/Drugs
OCoagulation Disorder
OEpilepsy, Seizures, or Fainting SpellsqExcessive Bleeding
OHeart Attack When?_____/ Congestive Heart Failure
OHeart Murmur *only if Premedication Required
ORheumatic Fever or Rheumatic Heart Disease
OqHerpes
OKidney Disease
OqLiver Disease
OMeniere's Disease (Dizziness)
OOrgan Transplant
OPre-Medication
ORadiation/Chemotherapy When? _____
ORespiratory Problem
OStomach ProblemsqStroke When? _____
OThyroid DiseaseqTuberculosisqTumorsqUlcersqVenereal Disease/ STD's
ODiabetes
OGlaucoma
OAngina Pectoris
OArthritis
OArtificial Joint
OHepatitis
OCongenital Heart Defect
OCrohn's Disease
OSpina Bifida
OShingles
OHeart Valve Replacement
ODepression
OHigh Blood Pressure
OLeukemia
OMental Disorder
OMitral Valve Prolapse
OPacemaker
OPsychiatric Care
ORheumatism

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List any Medications you are currently taking(Apunte cualquier medicamiento que este tomando):

_____

_____

Any disease or condition not listed above? **O**yes

FOR WOMEN(PARA MUJERES):
Are you pregnant (Esta embarazada)? SI / NO
Are you nursing(Esta dando pecho)? SI / NO

I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history. I understand incorrect information can be dangerous to my health. I authorize Dr. Luna to share any necessary documents/radiographs deemed necessary with the insurance company and/or professionals. I understand that I am financially responsible for all charges, whether or not paid by the insurance, and for all services rendered on my behalf. In addition, I authorize Dr. Luna to perform dental work on me.

(He respondido con sinceridad a todas las preguntas anteriores y acepto informar a esta oficina de cualquier cambio en el historial médico o dental. Entiendo que la información incorrecta puede ser peligrosa para mi salud. Autorizo al Dr. Luna a compartir cualquier documento / radiografía necesaria que considere necesaria con la compañía de seguros y / o los profesionales. Además, autorizo al Dr. Luna a realizar un trabajo dental en mi hijo.)

Signature(Firma):_____ Date(Fecha)_____