MARIBEL LOPEZ, D.D.S.
305-271-5321

8500 S.W. 92nd Street, Suite 203
Miami, Florida 33156

PATIENT REGISTRATION AND HISTORY

DATE:
Fecha: _____

PATIENT'S NAME: **BIRTHDATE:**
*Nombre del paciente:*_____ *Fecha de naciemento:*_____
NAME OF SPOUSE: **MARITAL STATUS:**
*Nombre del esposo(a):*_____ *Estado Civil:*_____
ADDRESS: **CITY:** **STATE:** **ZIP:**
*Direccion:*_____ *Ciudad:*_____ *Estado:*_____ *Codigo Postal*_____
HOME PHONE: **CELL PHONE:**
*Telefono de la casa:*_____ *Telefono movil:*_____
EMAIL ADDRESS:
Direccion de correo electronico: _____
PATIENT EMPLOYED BY: **WORK PHONE:**
Empleo del paciente: _____ *Telefono del trabajo:*_____
BUSINESS ADDRESS:
*Direccion del empleador:*_____
PRESENT POSITION:
*Ocupacion:*_____
SPOUSE EMPLOYED BY: **WORK PHONE:**
*Empleo del esposo(a):*_____ *Telefono del trabajo:*_____
BUSINESS ADDRESS:
*Direccion del empleador:*_____
PRESENT POSITION:
*Ocupacion:*_____
PERSON RESPONSIBLE FOR BILL:
*Persona responsable por la cuenta:*_____
SOCIAL SECURITY #: **SPOUSE #:**
*Numero del seguro social:*_____ *Esposo(a)*:_____
WHOM MAY WE THANK FOR REFERRING YOU?
Referido por: _____
NAME OF INSURANCE CO: **POLICY #:** **GROUP #:**
*Nombre del suguro:*_____ *Polisa:* _____ *Grupo:*_____

I authorize the release of medical information to process any of my insurance claims and I authorize payment of medical benefits directly to Maribel Lopez, DDS for services rendered. I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance of my account for any professional services rendered as well as any additional collection agency fees should their assistance become necessary. The undersigned agrees, whether he/she signs as a parent, spouse, guarantor, guardian or patient that in consideration of the services to be rendered to the patient, he/she herby individually obligates himself/herself to pay the account. Should the account be referred to an attorney for collection, the undersigned shall pay reasonable attorney's fees and collection expenses.

El (La) suscrito(a) autoriza que, toda la informacion medica necesaria para procesar cualquiera de mis reclamos a mi compania de seguros sea puesta a disposicion de esta. Asi mismo autorizo el pago de mis beneficios medicos directamente al Maribel Lopez, DDS. Entiendoy accepto que, independiente de mi condicion de asegurado(a), soy totalmente responsible de mi cuenta por los servicios profesionales recibidos en este centro. Si acaso esta cuenta fuese enviada a un servicio de cobranzas, todos los gastos que se originen de este recurso legal son tambien de mi responsabilidad y obligacion por cualquier balance pendiente que derive a causa cuentas legales y asumira costos de coleccion.

SIGNATURE: **DATE:**
Firma: _____ *Fecha:* _____

HEALTH HISTORY

DATE OF LAST HEALTH CARE EXAMINATION _____ **WHAT FOR?** _____
HAVE YOU BEEN HOSPITALIZED IN THE LAST 5 YEARS _____ **IF SO, FOR WHAT?**_____
HAVE YOU TAKEN ANY MEDICATIONS OR DRUGS IN THE PAST YEAR? ☐ **YES** ☐ **NO**
HAVE YOU TAKEN ANY MEDICATIONS, DRUGS OR PILLS TODAY? ☐ **YES** ☐ **NO**
ARE YOU CURRENTLY TAKING ANY MEDICATION, DRUGS OR PILLS? ☐ **YES** ☐ **NO**
IF YES, PLEASE LIST:

_____

ARE YOU AWARE OF BEING ALLERGIC TO OR HAVE YOU EVER REACTED ADVERSLY TO:
ANY MEDICATIONS OR SUBSTANCES ☐ **YES** ☐ **NO** **LOCAL ANESTHETIC** ☐ **YES** ☐ **NO**
IF YES, PLEASE LIST: _____ **WOMEN: ARE YOU PREGNANT?** _____
NAME OF YOUR PHYSICIAN: _____ **PHONE #** _____
ARE YOU RECEIVING CARE NOW? _____ **IF SO, NATURE OF CARE** _____

INDICATE WHICH OF THE FOLLOWING YOU HAVE HAD OR HAVE AT PRESENT: CHECK "YES" OR "NO" TO EACH ITEM

HEART FAILURE	☐ YES ☐ NO	ARTIFICIAL JOINTS (HIP, KNEE, ETC.)	☐ YES ☐ NO
HEART DISEASE OR ATTACK	☐ YES ☐ NO	KIDNEY TROUBLE	☐ YES ☐ NO
ANGINA PECTORIS	☐ YES ☐ NO	ULCERS	☐ YES ☐ NO
CONGENITAL HEART DISEASE	☐ YES ☐ NO	DIABETES	☐ YES ☐ NO
HEART MURMUR	☐ YES ☐ NO	THYROID PROBLEMS	☐ YES ☐ NO
HIGH BLOOD PRESSURE	☐ YES ☐ NO	GLAUCOMA	☐ YES ☐ NO
ARTERIOSCLEROSIS	☐ YES ☐ NO	COSMETIC SURGERY	☐ YES ☐ NO
MITRAL VALVE PROLAPSE	☐ YES ☐ NO	EMPHYSEMA	☐ YES ☐ NO
ARTIFICIAL HEART VALVE	☐ YES ☐ NO	CHRONIC COUGH	☐ YES ☐ NO
HEART PACEMAKER	☐ YES ☐ NO	TUBERCULOSIS	☐ YES ☐ NO
HEART SURGERY	☐ YES ☐ NO	ASTHMA	☐ YES ☐ NO
RHEUMATIC FEVER	☐ YES ☐ NO	HAY FEVER	☐ YES ☐ NO
ARTHRITIS	☐ YES ☐ NO	ALERGIES OR HIVES	☐ YES ☐ NO
RHEUMATISM	☐ YES ☐ NO	SINUS TROUBLE	☐ YES ☐ NO
CORTISONE MEDICINE	☐ YES ☐ NO	RADIATION THERAPY	☐ YES ☐ NO
DRUG ADDICTION	☐ YES ☐ NO	HEPATITIS A (INFECTIONS)	☐ YES ☐ NO
STROKE	☐ YES ☐ NO	HEPATITIS B (SERUM)	☐ YES ☐ NO
CHEMOTHERAPY	☐ YES ☐ NO	HEPATITIS C	☐ YES ☐ NO
VENEREAL DISEASE	☐ YES ☐ NO	SICKLE CELL DISEASE	☐ YES ☐ NO
A.I.D.S.	☐ YES ☐ NO	LIVER DISEASE	☐ YES ☐ NO
H.I.V. POSITIVE	☐ YES ☐ NO	YELLOW JAUNDICE	☐ YES ☐ NO
COLD SORES/FEVER BLISTERS	☐ YES ☐ NO	EPILEPSY OR SEIZURES	☐ YES ☐ NO
BLOOD TRANSFSION	☐ YES ☐ NO	FAINTING OR DIZZY SPELLS	☐ YES ☐ NO
HEMOPHILIA	☐ YES ☐ NO	NERVOUSNESS	☐ YES ☐ NO
ANEMIA	☐ YES ☐ NO	PSYCHIATRIC TREATMEMT	☐ YES ☐ NO

DO YOU WISH TO SPEAK TO THE DOCTOR PRIVATELY ABOUT ANYTHING? ☐ YES ☐ NO

DENTAL HISTORY

DATE OF LAST DENTAL EXAMINATION_____ WHAT FOR_____
LAST CLEANING _____ LAST X-RAY EXAMINATION _____
HAVE YOU EVER RECEIVED TREATMENT FOR "GUM" DISEASE ☐ YES ☐ NO
HAVE YOU EVER HAD BRACES ☐ YES ☐ NO EVER BEEN TREATED FOR A "BITE" PROBLEM ☐ YES ☐ NO
DO YOU OR HAVE YOU EVER HAD RINGING IN YOUR EARS ☐ YES ☐ NO EAR ACHE ☐ YES ☐ NO
CLICKING OR POPPING OF JAW UPON OPENING OR CLOSING ☐ YES ☐ NO
CHRONIC HEADACHE OR NECKACHE ☐ YES ☐ NO DO YOU CLENCH OR GRIND YOUR TEETH ☐ YES ☐ NO
DO YOU HAVE TIRED OR ACHY JAW MUSCLES ☐ YES ☐ NO
MAY WE REQUEST YOUR DENTAL RECORDS ☐ YES ☐ NO

THIS INFORMATION WAS GIVEN BY (Signature) _____