# PATIENT REGISTRATION

**Family Dentistry of Bonita** 28315 South Tamiami Trail Phone: 239-949-1655
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Name/NombreApedillo_____
Address/Direccion_____
City/Ciudad_____
E-mail/Correo Electronico_____
Spouse Name/Nombre de esposo/a_____
Home Phone/Tel._____Work/Trabajo:_____Cell:_____
Date of Birth/Fecha de naciminto:_____ / SS#_____
Employer Address/Direccion de Empleo_____
Who referred you?/ Quien lo recomendo?_____

## Dental Information/ Informacion Dental

When was your last dental visit?_____Scared of the dentist? Circle One 1 2 3 4 5 6 7 8 9 10
Cuando fue su ultima visita al dentista? Fearless Trembling
Do you have a specific problem?_____Do you have a sensitivity to hot /cold___Biting___sweets____
Tiene algun problema en especifico? Calor/frio___mordida___dulces____
Do you have any health/medical condition where pre medication is necessary?_____
Tiene alguna condicion medica donde pre medicacion sea necesaria?
Do you have ___Bleeding gums/ Sangre en la s encias ____Jaw joint pain/ Dolor en la quijada___Loose Dentures/ Dentadura floja
Usted Tiene?____Loose teeth/ Dientes flojos____clicking jaw/ click en la quijada____loose caps/ Corona suelta____Sinus problems/
Problema en el sinus____Headaches/Dolor de cabeza____cosmetics concerns/ Preocupacion cosmetica

## Medical Information/ Informacion Medica

Physician/Medico Primario_____Address/ Direccion_____Phone/Tel._____
Pharmacy/Farmacia_____Phone/ Telefono_____
Please check each line Yes or No if you have in the past had the following:
Por favor marcar cada linea Si o No si ha padecido en el pasado las siguientes condiciones:

| Yes | No | | Yes | No | | Yes | No | | Yes | No | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | **Cardiovascular** | | | **Lungs/Pulmones** | | | **Other** | | | |
| ____ | ___ | Angina | ___ | ___ | Asthma/ Asma | ___ | _____ | Cosmetic Surgery/ Cirugia cosmetica | ____ | ___ | Bleeding Problems/ Sangramiento |
| ____ | ___ | Arrhythmia | ___ | ___ | Emphysema | | | | | | |
| ___ | ____ | Attack/ Ataque | ___ | ____ | Tuberculosis | ____ | ____ | Diabetes | ___ | ____ | Ulcers/ Ulcera |
| ____ | ____ | Heart Mumur/ Mitro Valve Prolapse/ Soplo | ____ | _____ | Cough/ Tos | ____ | ____ | Adrenal Gland Disease | ____ | ___ | Cold Sores |
| | | | | | | ____ | _____ | Kidney Disease/Rinon | ____ | ___ | Venereal |
| ____ | ____ | Heart Failure/ Fallo Cardiaco | | | **Liver/Higado** | ____ | _____ | Thyroid/Parathyroid Dis. | | | Disease/ Venereas |
| ____ | ____ | Congenital Heart Valve | ___ | ____ | Hepatitis | _____ | _____ | Radiation Cobalt Treatment | ___ | __ | Bruise |
| ____ | ____ | Artificial Heart Valve/ Valvula artificial | ____ | ____ | Cirrhosis | _____ | _____ | Chemotherapy/ Quimoterapia | Easily | | |
| | | | ____ | ____ | Yellow Jaundice | _____ | _____ | Osteoporosis | ____ | ____ | Psychiatric |
| ____ | ____ | High Blood Pressure/ Alta Presion Arterial | | | **Blood/Sangre** | _____ | _____ | Arthritis | | | Care |
| | | | ____ | _____ | Anemia | ____ | _____ | Rheumatism | ____ | _____ | Fainting/ |
| ____ | ____ | Low Blood Sugar/ Baja azucar en la sangre | _____ | ____ | HIV/ Sida | _____ | _____ | Glaucoma | | | Desmayos |
| | | | ____ | _____ | Transfusion | _____ | _____ | Joint Replacement/ Reemplazo de Cadera | | | |
| ____ | ____ | Stroke/ Derrame | | | | | | | ___ | ___ | Cancer____ |
| | | | | | | | | | ___ | ____ | Allergies/ Alergias |
| | | | | | | | | | ___ | ____ | Scarlet Fever\ |
| | | | | | | | | | ____ | ____ | Rheumatic Fever |
| | | | | | | ____ | ____ | Epilepsy/ Convulsions/ Epilepsia/ Convulsiones | | | |
| | | | | | | | | | ____ | _____ | Fever Blisters |

**Please check and elaborate in the space provided.**

Any serious illness past or present? Yes___ No__ _____
Alguna enfermedad seria en el pasado o presente?
Are you taking medications now? Yes__- No __ _____
Are you pregnant? Yes__ No___ _____
Estas embarazada?
Any allergies to food, drugs, or medicines? Yes__ No___ _____
Alguna alergia a comida, drogas o medicinas?
Are you currently under a physician 's care? Yes___ No __ _____
Esta actualmente bajo cuidado medico?
Do you have dental insurance? Yes__ No_____
Tiene seguro dental?

The above information is correct to the best of my knowledge: Name/Nombre_____ Date/Fecha_____